HEALTH CARE COST CONTROL ACT OF 1983

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

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HEALTH CARE COST CONTROL ACT OF 1983

WEDNESDAY, SEPTEMBER 28, 1983

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The subcommittee met at 10 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andrew Jacobs, Jr. (chairman of the subcommittee) presiding.

[The press release announcing the hearing follows:]

[Press Release of Friday, Sept. 16, 1983]

HON. ANDY JACOBS, JR., DEMOCRAT OF INDIANA, CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS ANNOUNCES A HEARING ON H.R. 3261, THE HEALTH CARE COST CONTROL ACT OF 1983, TO BE HELD ON SEPTEMBER 28, 1983

The Honorable Andy Jacobs, Jr., (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittee will hold a public hearing on the bill H.R. 3261, The Health Care Cost Control Act of 1983. The hearing will be held on Wednesday, September 28, 1983, beginning at 10:00 a.m. in the Ways and Means Committee Main Hearing Room, 1100 Longworth House Office Building.

H.R. 3261 is designed to encourage States to develop health care cost containment systems. The proposal is a two-stage plan. During phase I, a Federal limit would be placed upon the permissible rate of increase in hospital costs. There would be limits on the increases applicable to both public and private payors.

The bill would also establish a maximum permissible rate of increase on physician's fees and physicians could not charge more than the maximum fee established by the bill.

Under phase II, a State would be permitted at any time to apply to operate its own cost containment program. The principal requirements would be that (1) the State program cover all payors, (2) payment under the program be prospective and (3) all payors be treated equitably.

Under phase II, physician services, outpatient services, and diagnostic and X-ray services would be subject to limits negotiated between providers, consumers, and the State.

Where a State has not established a program by October 1, 1985, the Secretary of Health and Human Services would be permitted to continue to operate the Federal program in that State or to establish a prospective payment system for the State.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony before the Subcommittee must submit their requests to be heard by telphone to Harriett Lawler (202) 225-3627) no later than noon, Thursday, September 22, 1983, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Building, Washington, D.C. 20515. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

In order to assure the most productive use of the limited amount of time available to question witnesses, witnesses scheduled to appear before the Subcommittee are

required to submit 100 copies of their prepared statement to the Main Committee Office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance.

Each statement to be presented to the Subcommittee or any written statement submitted for the record must contain the following information:

1. The name, full address, and capacity in which the witnesses will appear (as well as a telephone number where he or his designated representative may be reached);
2. A list of any clients or persons, or any organization for whom the witness appears; and
3. A topical outline or summary of comments and recommendations.

For those who wish to file a written statement for the printed record of the hearing, *six copies* are required and may be submitted by the close of business Wednesday, October 12, 1983, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Represenatatives, Room 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office during the hearing.

Chairman JACOBS. The Ways and Means Subcommittee on Health is holding this hearing on the subject of health cost containment.

The first witness appears not to be present, so we will go down to the Health Security Action Council, Douglas A. Fraser, acting chairman. Mr. Fraser is present.

The Chair will observe that the administration has been invited to testify on this proposed legislation and has declined to do so. Each individual must draw his own references from the refusal to testify, although it has been said that silence is assent.

With that, we shall recognize Mr. Douglas Fraser.

Welcome to the committee, Mr. Fraser. I am told by my sheet here that since you are the moving party, you have 20 minutes.

STATEMENT OF DOUGLAS A. FRASER, NATIONAL CHAIRMAN, HEALTH SECURITY ACTION COUNCIL, ACCOMPANIED BY MELVIN A. GLASSER, DIRECTOR

Mr. FRASER. Thank you, Mr. Chairman. I will not take that much time.

I am Douglas Fraser and I am chairman of the Health Security Action Council. We are an organization of 100 American citizens who are working together with a coalition of 70 labor-consumer senior citizens, women, farm, and youth organizations, to reform the Nation's health care system and extend access to it to tens of millions of Americans who are now underserved and left out of the system.

I am accompanied by Mel Glasser, who is the director of the Health Security Action Council.

There are so many reports and figures quoted on costs and escalation of cost of health care in this country that by this time, the members of this committee and, indeed, members of the public must find them almost meaningless. The facts are that we are spending a larger portion of our gross national product for health services than ever before in our national history.

The rate of escalation of health costs and the even greater rate of increase of health insurance premiums has continued at a steeper and steeper pace over at least the last decade. Despite increased expenditure outlays, some 30 million Americans have no health care protection at all and 10 to 15 million more have so little it could be characterized as insignificant.

Important life-saving health programs ranging from medicare to childhood immunizations have seen their costs go up and their benefits eroded as a result of cost inflation. The American Hospital Association boasts that hospital expenses increased by only 12.4 percent—annualized rate—in the first 6 months of 1983; and consumers groan that this continues to rise at more than three times the increase in the cost of living.

Millions of Americans are today denied health insurance protection because they are unemployed, or partially employed, or work in jobs which do not provide this benefit—or have just been priced out of the market.

To date, very little which has taken place in either the voluntary or public sectors appears to have had any impact on the relentless upward course of health care inflation which continues to run at two to three times the increase in the cost of living.

On the contrary, we are troubled that in the efforts to contain costs many leading policymakers in and out of Congress appear to have disregarded the quality of care paid for with escalating health expenditures. This is poor economics and poor medical care.

Professional spokesmen for the American Medical Association repeatedly speak out for increased preventive and diagnostic services. They have taught us how important these services are in safeguarding lives and preventing needless deaths. Then their spokesmen come up on the Hill and call for more cost-sharing, thus creating increased difficulty of access to these services that they are advocating.

They would do well to review the recent report of the Minister of National Health and Welfare of Canada, in which she states:

> Increasing user fees can only reduce total health care expenditures by reducing the number of health services sought. Otherwise, it is not reducing costs but merely changing which pocket it comes out of.
>
> If there are parents who do not take their child to the emergency room for a fever because they cannot afford the payment, there will also be parents whose child has a fever due to meningitis and who do not go to the emergency room because they do not have the fee available. Without medical training, it is difficult for a person to know when an illness really does require immediate attention.

Mr. Chairman, I shall not attempt to comment on the various nostrums which have been proposed to stay this runaway health inflation. Reducing benefits, making it harder for the poor to get care, introducing competition, cost-sharing, forcing beneficiaries to give up all or part of their insurance, preferred providers, have all been tried or are being tried, with thus far little impact.

It was the awareness of the developing trends in health costs which we now see in full flower and the need for system reform that caused our committee to be formed 14 years ago and to begin to formulate a plan for long-range reform. This plan is still needed.

Our committee has been, however, deeply troubled by the ineffective cost containment programs adopted by the 97th and 98th Congresses and by the retreat from responsibility which we perceive many have adopted as a solution to the problems.

We therefore appear before you in support of H.R. 3261, because in the short run, it is a constructive, pragmatic, profoundly sound way of calling a halt to runaway health costs without punishing

consumers, particularly those who are poor, by denying access to needed health care.

We support this legislation because it covers the principal elements which affect costs: hospitals, physicians and other professionals, laboratory and X-ray services, health maintenance organizations, and new procedures and technology. Nursing homes would also be included, if feasible.

It is based on the conviction that effective cost containment cannot be achieved by trying to save money in one sector, like hospitals, or in one program, like medicare. This approach only results in shifting costs to the other elements or programs.

Furthermore, it recognizes the interrelatedness of public and private health care programs. Provision is made, therefore, as it must be, to bar cost escalation and cost shifting from the public to the private sector and vice versa.

The Congress and the administration cannot and should not be engaged in the charade of claiming to save money by reducing payments for certain services in medicare through shifting them onto private insurance, private employers or patients.

Health insurance premium payments for Federal workers are about to increase again, this time by some 19 percent. Make no mistake about it: This is largely canceling out the pay increase these workers are scheduled to receive. But comparable premium increases proposed and imposed on non-Government workers are no less a hardship on them. We seek a means of containing the costs on both governmental and private sector workers.

This is a two-stage or phase program. Phase I becomes operative 90 days after the legislation is passed. In this phase, permissible price increases are halted while the States are given a 2-year period to develop and put into operation a continuing cost containment mechanism.

If a State is unable or unwilling to develop a plan which meets the criteria in the legislation, the Federal Government would be authorized to step in.

During phase I, hospitals would be required to limit their annual budgets to total inpatient revenues in the previous year, or a model year in 1 of the past 3 years, plus the increase in "market basket" index for hospital inpatient operating costs between the previous year and the current year.

Similar limitations would be placed in phase I on expenditures for physicians and other professional providers, lab and X-ray services and health maintenance organizations. The Secretary of HHS would be required to conduct a study and report on the feasibility of containing nursing home costs in a manner similar to that described for hospitals.

A National Professional Advisory Committee on New Procedures and Technology would be established, HMO's would be brought into the system, and contracts negotiated with them.

Phase II, which would become operative after 2 years, would give each State control over its health cost programs, within established Federal limits.

A hospital prospective budgeting system would be required for each participating State. The State would be required to hold total

expenditures for hospitals to the previous year's expenditures within the State, plus the increase in the "market basket" index.

The States could, as long as they remained within the predetermined ceilings, use their own methods of determining how to pay hospitals within the system. This could be done in a variety of ways.

Prospective budgeting by category of hospital—e.g., teaching hospital, small, medium or large community hospital, rural hospital, et cetera; formulas to set limits on what could be charged various payors; budget reviews of each hospital; capitation payments for defined populations; diagnostic related grouping [DRG] reimbursement.

Half a dozen States have already had considerable success in holding down increases in health care costs through mandatory State commissions. These could be continued. This program would also encourage testing, on a comparative basis of the recently announced DRG—diagnostic related groups—prospective payment program.

Physicians and other professional providers: Reimbursement arrangements, including fee schedules, would be based on negotiated agreements by the providers with the State agency. Representatives of medicare, the prepayment organizations, and consumers would be part of the negotiations.

Laboratory and X-ray services: A laboratory and X-ray payment committee under the State agency, and consisting of representatives of the public agency, medicare, laboratory and X-ray providers, insurance companies, and consumers would negotiate annual reimbursement schedules. The committee would be empowered to review and set standards for appropriateness and frequency of the procedures and technology use.

In our view, H.R. 3261 would do the following:

No. 1, make possible substantial Federal budget savings for medicare, medicaid and other personal services programs for the next year, and for subsequent years. This, however, would be achieved without further slashes in benefits and eligibility.

No. 2, provide for comparable savings for private sector health insurance.

No. 3, encourage States to participate in and run the plan, and receive incentive payments in the form of reductions in the required medicaid matching funds.

No. 4, new protection would be provided to private health insurance by putting an end to further cost shifting.

No. 5, the States would have substantially increased authority, within Federal guidelines, to control all health care costs within a State.

No. 6, the plan would make possible, over the next 2 years, a system to contain health care costs in an orderly way. The frantic, haphazard annual efforts by the Congress to effect needed savings would largely be avoided. Program planning and rationalization of services would be encouraged and would be related to necessary fiscal constraints.

H.R. 3261 commends itself to us, as I believe it should to you, because it not only covers the public and private sectors and because it places much of the responsibilities on the States, but because it

also recognizes that every principal aspect of health care costs should be incorporated in a meaningful containment plan.

Therefore, it recognizes and brings within the scope of the legislation not only hospitals, but also nursing homes, physicians and other professional providers, laboratory and X-ray services, health maintenance organizations, new procedures and technology, and long-term care.

Its provision for a 2-year, phase-in period and for substantial negotiation between payors and providers, with consumers represented, adds a new and needed dimension to health programing.

Our major regret is that because it is proposed as a cost-containment plan, H.R. 3261 does not extend eligibility for care to tens of millions of Americans now without such protection, nor does it provide for new needed benefits in present programs. It is our hope, however, that once it begins to achieve what we believe are its realistic goals, there will be new opportunities for extending eligibility and benefits.

H.R. 3261 begins to put into place sound, long-range plans for continuing restraint on health cost increases in both the public and private sectors. It brings together the principal parties in the health care program in annual negotiations designed to work out State and local cost-containment issues. It is a consumer-oriented plan which is realistic and achievable.

As such, it merits support by all Americans. It is a constructive alternative to cost-containment efforts which until now have been tried and have failed.

Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Fraser.

Mr. SHANNON. Thank you for your excellent testimony, Mr. Fraser. I want to commend you and your organization, and particularly Mr. Glasser, for the lead that you are taking in developing this legislation and in dealing with this issue in a broader sense over the last several years.

I just have one question that I would like to ask you, and that concerns what has been one of the areas criticized in this legislation which is that it would be a national regulatory scheme and that it gives the Federal Government too much regulatory power in controlling health care costs.

I wonder if you could comment on that aspect of it, particularly in light of what we did with the DRG system and medicare earlier this year?

Mr. FRASER. Well, first of all, Congressman Shannon, it encourages State participation. The fact of the matter is that if the system would work as we projected and as we advocate, the regulatory level would be at the State level. But in addition to that, within the plan as the statement indicates, there is a lot of room for negotiations and participation between all the parties. So I would argue that contrary to the charge that there is more Federal regulation, there would be a minimum of Federal regulation if the States fulfilled their obligations and responsibilities.

In addition to that, I might say there are some 11 States that have their own plans. It looks like 6 of the 11 now have real measurable cost containment in place. And what we would be saying, in effect, that those States which can work out programs within the

framework would not even be interfered with by the Federal Government.

Mr. SHANNON. Well, as you know, Mr. Fraser, my State, Massachusetts, has one of the toughest plans I think, and what is interesting from a political perspective about that plan is that the lead in Massachusetts was taken by the Business Roundtable in putting that plan into place, together with people in government and people in labor; they joined together to deal with what they saw as a problem for everybody, and I would hope that other States under this legislation would accomplish the same thing.

And I greatly appreciate your testimony this morning. Thank you.

Mr. FRASER. If I might say to that point, in the State of Michigan, there is a new awareness because the costs are so horrendous and now we have a committee called the Michigan Alliance, composed of just business and labor, and we are seeking ways within our own structure to introduce a cost containment program that would begin to do the things that this legislation is proposing.

Mr. SHANNON. Thank you very much.

Mr. JACOBS. Mr. Moore?

Mr. MOORE. No questions.

Mr. JACOBS. Mr. Duncan?

Mr. DUNCAN. No questions.

Mr. JACOBS. Mr. Fraser, I am sure you will discover as these hearings go forward that nobody was kidding when we said "Damn the darkness and damn the one who lights the candle." The committee is grateful for some imaginative thinking on behalf of your committee and your contribution to the solution of what promises to be, so long as we don't get into many wars between now and then—it is a major American dilemma of the 1980's.

Thank you very much for your testimony.

Mr. FRASER. Thank you very much, Mr. Chairman.

STATEMENT OF HON. BARBARA A. MIKULSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. JACOBS. The committee is honored to welcome our colleague, Congresswoman Barbara Mikulski of Maryland.

Ms. MIKULSKI. Mr. Chairman, I want to thank you and the committee for the opportunity to appear before the subcommittee this morning.

I understand that I now have a record to live up to as presenting most crisp and efficient and to-the-point testimony. I would like to thank the chairman for his work on the oversight hearing on the Office of Direct Reimbursement and just as I was crisp in my commentary there, I hope to do the same this morning.

Mr. JACOBS. If I may say, another day, another dollar.

Ms. MIKULSKI. I welcome any tribute from Caesar, Mr. Chairman.

Mr. Chairman, I have come to voice my strong support for H.R. 3261, the Health Care Cost Control Act, introduced by Congressman Shannon and myself in the House, and Senator Kennedy in the Senate.

As a member of the Energy and Commerce Subcommittee on Health and the Environment, I spent several sessions of the Congress working to find ways to reduce the cost of health care in this country.

This problem is of special concern to the elderly, who often face increased health problems at the time that they have less available income. But it is also of concern to all my constituents who see an increasingly large share of their income eaten up by high medical bills.

Every family in America is concerned about the cost of health care and acute medical problems. Large businesses, megacorporations like the automobile industry, and small businesses like the small retail haberdashery outlet, are all concerned about health care. It has been a hallmark of the American private sector that they have voluntarily or through collective bargaining provided health care benefits as a fringe benefit to their employees because of the skyrocketing inflation of professional health care costs. This is added to the cost of doing business in the country.

It is estimated that it costs one of the major automobile corporations in this country approximately $800 per employee to furnish health care costs. This problem affects us all, and I am sure you have heard the same concerns in your own district. And if there is ever a coalition issue for labor and management and all of the various interest groups to get together on, it is this issue.

It is clear that a major change is needed in our health care financing system. Up to very recently, Federal reimbursement practices have been part of the problem of the rapidly escalating health care costs. Whatever we were asked to pay for we did, at least up to 80 percent of reasonable costs, but no one defined what "reasonable costs" were.

Your subcommittee took the first important step in responding to this problem when you reported out the prospective reimbursement payment system for medicare, and I commend your leadership in this area.

However, we all realize that this is not the complete answer to the problem. I believe that H.R. 3261 is the next step in our efforts to control health care costs, and I believe that it provides an innovative approach to solving a complex problem.

Mr. Chairman, I like the fact that we are challenging the health care costs. The previous administration advocated a hospital cost containment program which meant that all we were looking at was containing the costs in acute care facilities, having a national model that had no local or State flexibility to it, and I believe offered very serious dangers to the philanthropic hospitals who assume a great deal of burden for the charity cases in this country.

This legislation is an improvement because of its health care cost control and also provides for local and State innovation and flexibility. You know what this program provides, but one of the things that I like the best about it is that it sets Federal objectives, but allows the State to determine what mechanisms they want to use in order to meet these objectives. This would allow each State to meet the needs dictated by their own economic and demographic situation.

That means a State like Florida that has a substantial number of elderly has a very different set of problems in dealing with health care costs than the State of Maine. It also will encourage innovation at the local and State level.

I found that most good ideas don't come from the Congress, Federal agencies, think tanks, or grant junkies that go around looking how they can get Federal money to tell us how to spend more Federal money. But really the best ideas have come from people at the local level who are closest to the people and who are closest to the problem.

This legislation also rewards the good guys. States participating in this plan would receive incentive payments in the form of reductions in the funds they are required to spend for medicaid matching. I have always believed that Government should have good-guy bonuses to award those agencies that comply with the law and develop disciplines rather than punishing those who choose to ignore it.

This legislation also provides savings for the private sector insurance as well as public programs. Too often we pass legislation that only afffects the Federal Government and not the private sector.

I have always supported the concept that Federal standards should treat public and private sector programs in the same manner. You know there are many aspects to this proposal that deal with other cost issues, physicians and other health professionals, laboratory and X-ray services and many others.

For all the reasons I have mentioned, Mr. Chairman, I urge your careful consideration of this legislation. We must all be active and adamant in reaching these goals of meaningful health-care-cost containment. I firmly believe that this legislation is an excellent way to approach that goal, and I thank you for providing me with this opportunity to share these views.

I also would like to bring to the Chair's attention and to the committee's attention, that we in Maryland have had a very effective and efficient hospital cost containment program that has been a very important first step in disciplining costs within our own State. It has resulted in enormous savings in our medicaid program and savings to the Federal Government in medicare and in private sector insurance outlays because of these disciplines that we have had.

So, for these reasons, Mr. Chairman, I urge action on this legislation, and we will be happy to answer any questions that you might have.

[The prepared statement follows:]

STATEMENT OF HON. BARBARA A. MIKULSKI, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for the opportunity to appear before your subcommittee this morning.

I have come to voice my strong support for H.R. 3261, the Health Care Cost Control Act of 1983, introduced by Congressman Shannon and myself in the House and Senator Kennedy.

As a member of the Energy and Commerce Subcommittee on Health and the Environment, I have spent several sessions working to find ways to reduce the cost of health care in this country.

This problem is of special concern to the elderly, who often face increased health problems at the time that they have less available income. But it is also of concern

to all my constituents who see an increasingly large share of their income eaten up by high medical bills. This problem affects us all and I am sure that you, too, have heard these concerns raised in your districts.

It is clear that a major change is needed in our health care financing system. Up to very recently, federal reimbursement practices have been part of the problem of the rapidly escalating health care costs. Your subcommittee took the first important step in responding to this problem when you reported out the prospective reimbursement payment system for medicare, and I commend your leadership in this area.

However, we all realize that this is not the complete answer to the problem. I believe that H.R. 3261, *is* the next step in our efforts to control health care costs and I believe that it provides an innovative approach to solving a complex problem.

The legislation mandates a two-phased program: First, it requires an immediate halt to permissable hospital price increases; secondly, it provides for a two-year period that each state can use to develop its own cost containment mechanism.

I favor this legislation approach because it embodies several principles that I believe lead to sound Federal legislation.

It sets Federal objectives, but allows the States to determine what mechanisms they want to use in order to meet these objectives. This will allow each State to meet the needs dictated by its own political, economic and geographic situation. It will also encourage the development of innovative methodologies growing out of local and State experiences.

I have found that many of the best ideas do not come from the Congress or the Federal agencies, but rather, from the people at the local level who are closest to the problem.

This legislation rewards the "good guys". States participating in the plan would receive incentive payments in the form of reductions in the funds they are required to spend for medicaid matching.

I have always believed the Government should reward those that comply with our laws, rather than only resort to punishing those who choose to ignore, or try to circumvent the law.

This legislation provides savings for private sector health insurance as well as public programs. I have always supported the concept that Federal standards and requirements should treat public and private sector programs in the same manner.

There are many other aspects of this legislation that I think are commendable. It covers the principal elements that affect costs: Hospitals, physicians, and other professionals, laboratory and X-ray services, health maintenance organizations, and new procedures and technologies. It studies the feasibility of including nursing homes in cost containment programs, and avoids any possibility that costs would be shifted to other parts of the health care system.

For all the reasons that I have mentioned, Mr. Chairman, I urge your careful consideration of this legislation. We must all be active and adamant in reaching our goals of meaningful health care cost containment. I firmly believe that this legislation is an excellent way to approach that goal.

Thank you, again, for providing me with this opportunity to share my views with you.

Mr. JACOBS. We thank you, Ms. Mikulski. The PA system isn't working very well. Did you say the good-guy award or did you say good-old-boy award?

Ms. MIKULSKI. No; I wouldn't say good old boy. This was part of my olive branch. I said a good-guy bonus. Good old boys have gotten bonuses enough.

Mr. SHANNON. Around here I think that is certainly true.

Ms. Mikulski, thank you for your testimony.

You referred to the Maryland system which has been in place since 1975, is that correct?

Ms. MIKULSKI. Yes.

Mr. SHANNON. I wonder whether you could comment on whether or not the State under that system has had any difficulties in maintaining quality health care? Has anybody in the medical community raised questions about any deterioration in the quality of health care as a result of this system?

Ms. MIKULSKI. The answer is no, Mr. Shannon. Initially when the legislation was being considered in the State general assembly, there were concerns, would we end up rationing health care or creating these types of problems. Because hospitals were made part of the process, rather than viewed simply in an adversary relationship, the answer has been no.

Mr. Shannon, as you know, we have great institutions, world-class institutions like Johns Hopkins, that provide both health care to the poor and Nobel-class-type research as well as teaching. They have been able to meet their responsibilities to their patients, to the medical students and to the world who looks to it under this mandate.

And I think if a world-class institution, like Hopkins, can meet all of those responsibilities under our framework, I think it bodes well for other institutions.

Mr. SHANNON. As you know, Ms. Mikulski, I think pretty highly of Johns Hopkins myself, and when I was a student there, I had occasion to be treated in five hospitals in Maryland, and I think that this question of the quality of health care is really going to be at the nub of this whole issue as we debate what we are going to do about holding down health care costs.

There are all sorts of bugaboos always raised about what happens to quality health care. I can say in my own State of Massachusetts, which has a similar system in effect now, that the medical community is very enthusiastic about the way in which it worked and feels that it is necessary to institute that kind of system.

I think the Maryland experience is really going to be very important in discussing this issue in the next few months.

Ms. MIKULSKI. Mr. Shannon, also the savings of hospitals were achieved not by shortcutting clinical practice but in management efficiencies that were ranging from better use of energy and energy conservation, cutting the cost of doing business to clinical oversight in areas of unnecessary testing and a variety of other things that puffed the costs up.

But working in cooperation with hospital administrators and clinical directorates, we were able to achieve savings through management, not through shortcuts in clinical practice.

Mr. SHANNON. Thank you very much for your testimony.

Mr. MOORE. I have no questions, Mr. Chairman.

Thank you very much.

Mr. JACOBS. Ms. Mikulski, we thank you for your contribution to the record.

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Mr. JACOBS. Our next witness is Senator Edward Kennedy of Massachusetts. Senator, we welcome you to the committee. You may proceed in your own fashion.

Senator KENNEDY. Thank you very much, Mr. Chairman.

I am pleased to have the opportunity to testify on the vitally important subject of controlling health care costs, and I applaud your committee's effort to address this critical issue. The crisis in health

care costs we confront today threatens the health and well-being of every citizen of our country.

Rising health care costs are bankrupting our businesses and industry, distorting the Federal budget, impairing the security of our senior citizens and providing the Reagan administration, the most antielderly in our Nation's history, with an excuse to savage the medicare program.

Mr. Chairman, I held a forum on medicare last March, and some of the heartrending stories we heard at this forum demonstrate the terrible effect that health care cost inflation is having on the people of this country. Mrs. Gerry Sherline is one such case. Mrs. Sherline is a 34-year-old widow paralyzed from the neck down. Despite her severe handicap, Mrs. Sherline manages to care for her two children at home with the help of social security, which provides her entire income, and medicare, which provides her entire health insurance coverage.

Mrs. Sherline has been barely able to get by on her existing income and coverage. Last year she had to pay the deductible of $264 for each of two hospitalizations, as well as extensive doctors' bills not fully covered by medicare. If Mrs. Sherline has to go to the hospital next year, she will have to pay a deductible of $350. The doctors' bills that medicare does not fully cover are going up 18 to 20 percent a year.

Mr. Chairman, the continued escalation of health care costs threatens to rob Mrs. Sherline of her ability to stay in her home and care for her children—an ability she has fought so heroically to maintain.

Mr. Lou Minafra is a married 66-year-old who operates a retail carpet store in Pittsfield, Mass., and is a former Republican county chairman. His 55-year-old wife is in ill health, and Mr. Minafra himself has been hospitalized three times in the last 8 years. His income is about $7,500 a year. His supplemental health insurance cost him $300 per month.

Mr. Minafra has been able to manage the cost of his hospitalization and his wife's ill health because of the supplemental coverage he has purchased. Paying that insurance at $300 a month stretches Mr. Minafra's resources to the limit. Mr. Minafra testified that hospital bills have become such a burden that he would rather stay home and die than subject his family to mounting debt from hospital costs.

Mr. Chairman, these cases are only the tip of the iceberg. It is simply intolerable to see our people's lives destroyed not by ill health but because they can't afford needed health care.

Mr. Chairman, one of the cruelest effects of the excessive inflation in health care costs has been its impact on medicare programs. Because of excessive health care cost inflation, medicare faces bankruptcy by 1988. By 2005 the medicare program faces a deficit of $1 trillion. The administration has used the medicare crisis as a pretext for savage cuts in the medicare program—$18 billion in benefit reductions over the next 5 years in the 1984 budget alone.

The administration actually seems to believe the ludicrous idea that medicare is in trouble because medicare benefits are too generous. The fact is, Mr. Chairman, medicare benefits are not generous enough. Beneficiaries must pay an average of 20 percent of

their incomes for health care costs, and that figure has been growing. According to the most recent data, beneficiaries must pay an average of $1,400 annually in out-of-pocket expenses.

I believe, Mr. Chairman, that you understand that the senior citizens over 65 years of age average anywhere from $25 to $30 a month just on prescription drugs. Under the various Federal programs there is no coverage for eye care or for dental care or foot care, and you go into any senior's home and ask them for raising of their hands for the ones that are spending over $20, $25, even $50 a month on prescription drugs, and you find generally half of the hands in the room go up.

So there are significant health care problems that our seniors are facing that are predictable and that are certain and that are not being addressed.

We are all familiar with the problems caused by medicare's failure to cover dentures. The only way that seniors can ever get teeth through medicare is by going through the trapeze of showing that they have got problems with their stomach because they can't digest their food and, therefore, you go through hours of staff time getting two or three different doctors to testify that it is the extraordinary exception, and then they get some dental care. It is a kind of morass that our seniors should not have to face.

Mr. Chairman, medicare is in trouble not because of excessive benefits, not because the elderly or disabled use more services than they need, but because of the excessive inflation built into the backward and inefficient health care incentive system as a whole.

Health care inflation is also an important factor in the growing budget deficit facing our Nation. Between 1970 and 1982, Federal health expenditures grew from $18 billion to $93 billion, not because we substantially increased benefits but because health care costs have raged out of control even with the administration's medicare and medicaid budget cuts. Medicare and medicaid will grow to $132 billion by 1988—over 70 percent growth in 5 years—and will account for about 17 percent of the total budget growth between 1984 and 1988.

We face pressing domestic health and welfare needs, such as education, job training, social services, and health insurance for the unemployed. Dropping scarce Federal dollars down the bottomless pit of unnecessary health care cost inflation is not one of those needs.

Mr. Chairman, it is time to liberate our deficit burdened Federal budget from the chains of health care inflation.

Skyrocketing health care costs are a growing burden on the competitiveness of American industry. Health benefits are the fastest growing component of business costs. This year premium increases of 20 to 40 percent in the cost of health care insurance are not uncommon. In 1983 American companies will pay an estimated $77 billion in health insurance premiums, more than they will pay out in dividends.

Mr. Chairman, it is time to put an end to these unnecessary burdens on American businesses and workers. The bill you are considering today, H.R. 3261, which I introduced to the Senate as S. 814, is a sound basis for building a health care cost control program of the future.

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Congressman Shannon, Congresswoman Mikulski and I worked with a number of groups and technical experts in developing this bill. Most notably, I am grateful for the assistance of senior citizens organizations and the Health Security Action Council.

This bill embodies features that must be a feature in any program to control health care costs.

First, only a comprehensive all-payers approach to cost control would be helpful. Attempts to control medicare or the private sector alone will lead to cost shifting rather than cost restraint.

I think we have already seen that in some of the preliminary efforts that have been made by the Congress in cost control. You put limitations on various reimbursement programs under the medicare and medicaid programs and hospitals just increase the costs in the private sector. We need to really address the issue, not simply promote cost transfers.

Second, the all-payers system must be built around incentives to providers to be more efficient. Loading costs on the consumers is not the answer. We hear that we have to sensitize our consumers to the problems of the increase in health care costs. The fact is, health care is not a traditional kind of an industry. More than 70 percent of health care costs are ordered not by consumers but by doctors and other professionals. Adding to consumer's burden is not going to help, and it is unfair.

Third, physicians must be part of any effective cost control program. Any approach that just controls hospital costs while continuing to encourage physicians to practice "sky is the limit" medicine will not work for the reasons I have just outlined.

Fourth, any effective cost control system must insure medicare solvency without reducing benefits or increasing taxes. We have submitted an addendum, Mr. Chairman, about how such a comprehensive control program could work and how the savings from such a program could eliminate the medicare deficit without reducing benefits or increasing taxes.

Fifth, any successful health care cost control program should be administered by the States under broad Federal guidelines. We have seen a number of States, including our own State of Massachusetts, that have established effective cost containment programs and still provide as fine a quality of medicine as any area in the country.

Finally, any effective cost control program must help protect medicare beneficiaries from the growing costs imposed by doctors who will bill more than the medicare recognizes as reasonable.

There are those who say those within the medical profession will not treat seniors if they are not allowed to pass on costs in excess of medicare's recognized changes. I do not believe this, Mr. Chairman. I challenge the medical profession in this country to live up to their commitment to provide affordable health care to senior citizens.

Since Congressman Shannon and Congresswoman Mikulski and I introduced this bill, I have continued to refine the ideas contained with a particular focus on the crisis facing medicare. I anticipate introducing my proposal to insure the solvency of the medicare program in the near future. The work of your committee in analyzing the proposal you now have will contribute immeasurably to the

bill I plan to introduce and to the eventual enactment of effective health care cost control.

I am mindful, Mr. Chairman, that only a few short years ago when, in the Senate we had actually reported out a cost containment program, that the increase in health care costs within the hospitals because virtually identical to the increase in overall inflation. And all of us heard, I am sure, this body as well as in the Senate, "Well, look, it is comparable to the rate of inflation. Just give the hospitals a chance, and we will see that they are going to do it voluntarily."

And now we find that health care cost inflates vastly exceeds the overall rate of inflation. The people that are paying for this excessive rate of health care cost inflates are the sick and the needy, American business and labor, and the American taxpayers.

Mr. Chairman, the time for action is now. We cannot afford to wait. I look forward to working with this committee as we develop a realistic and effective plan to solve the national crisis of unrestrained health care cost inflation and insure the solvency of the medicare program.

Mr. JACOBS. Thank you, sir.

[The prepared statement and addendum follow:]

STATEMENT OF HON. EDWARD M. KENNEDY, A U.S. SENATOR FROM THE STATE OF MASSACHUSETTS

Mr. Chairman, I am pleased to have the opportunity to testify on the vitally important subject of controlling health care costs. The Ways and Means Committee has shown leadership in this area before, and your action is holding these hearings today demonstrates your continued willingness to assume a responsible role in dealing with this issue.

Five years ago, the Ways and Means Committee reported legislation to establish a comprehensive hospital cost containment program—legislation also reported by the Senate Labor and Human Resources Committee under my sponsorship. The Congress as a whole, unfortunately, failed to show the same sense of responsibility as our Committees and did not adopt hospital cost control legislation.

As a result of this failure to act, excessive health care cost inflation has ceased to be a problem and became a crisis.

In the 6 years between 1977, when hospital cost containment was first proposed and today, the cost of a day of hospital care has risen from $124 to $304. Between 1977 and 1982 private health insurance expenditures have increased $37 billion, more than 90 percent. Medicare has almost tripled, from $21 billion to $51 billion annually. The share of GNP going to health has increased by 20 percent, to 10.5 percent. In the last year alone, health care costs increased at twice the rate of overall inflation and Federal expenditures for health financing programs increased 24 percent faster than the budget as a whole. This growth in Federal expenditures, moreover, occurred at a time when the Reagan Administration was cutting coverage, services, and benefits.

The crisis in health care costs threatens the health and well-being of every citizen of our country. Rising health costs are bankrupting our businesses and industry, distorting the Federal budget, imperiling the security of our senior citizens, and providing this most anti-elderly Administration in our nation's history with an excuse to savage the Medicare program.

Mr. Chairman, perhaps the cruelest effect of the excessive inflation in health care costs has been its impact on the Medicare program. The Medicare program is—after Social Security—the single most important Federal program assuring a decent, secure life for our nation's 29 million senior citizens and disabled beneficiaries.

But because of excessive health care cost inflation, Medicare faces bankruptcy by 1988. Over the next two decades between now and 2005, the Medicare program faces a deficit of one trillion dollars.

If we were to attempt to eliminate this deficit by raising Medicare payroll taxes, we would have to raise taxes almost 50 percent—and we know how little American business and labor can afford that. If we were to attempt to eliminate this deficit by

reducing benefits, we would have to reduce benefits by one third, and we know how little the elderly and disabled can afford to reduce their precious Medicare benefits.

The Reagan Administration has not yet formally proposed a program to prevent Medicare's bankruptcy, but the direction they want to take is crystal clear. The Reagan Administration has already been successful in enacting benefit reductions that will cost senior citizens and the aged $7 billion between 1982 and 1988. The Reagan Administration's 1984 budget proposals add insult to injury by loading a further $18 billion in added costs on retired and disabled beneficiaries in just the next four years.

David Stockman, the architect of the Reagan Administration's disastrous Social Security proposals has recently indicated his desire to impose a means test on Medicare beneficiaries.

The Reagan Administration actually seems to believe the ludicrous idea that Medicare is in trouble because Medicare benefits are too generous. The fact is, Mr. Chairman, Medicare benefits are not generous enough. Beneficiaries must pay an average of twenty percent of their incomes for health care costs. According to the most recent data, beneficiaries must pay an average of over $1,400 annually in our of pocket expenses. Approximately 50 percent of the physicians bills paid by Medicare beneficiaries require payment of not only the legally mandated 20 percent copayment but an additional amount as well because physicians do not accept Medicare recognized charges.

In March, I held a forum on the problems of Medicare. Some of the heart-rending stories told at this forum illustrate the cruel and unnecessary burdens excessive health care cost inflation and inadequate Medicare coverage has caused the aged and disabled. I would like to review some of these cases with you.

Mrs. Gerry Sherline is one such case. Mrs. Sherline is a 34 year old widow paralyzed from the neck down—who manages to care for her two children at home with the help of Social Security—which provides her entire income—and Medicare—which provides her entire health insurance coverage. Mrs. Sherline has been barely able to get by on her existing income and coverage. Last year, she had to pay the deductible of $264 for each of two hospitalization as well as extensive doctor bills not fully covered by Medicare. If Mrs. Sherline has to go to the hospital next year, she will have to pay a deductible of $350. The doctor bills that Medicare does not fully cover are going up 18–20 percent a year.

Mr. Chairman, the continued escalation of health care costs threatens to rob Mrs. Sherline of the ability to stay in her home and care for her two children—an ability she has fought so heroically to maintain.

Mrs. Loda Hawkins is a 78 year old widow. She has a $389 month Social Security check. She pays $82/month for rent and has a drug bill for treatment of high blood pressure of $50–$60 a month. Mrs. Hawkins sees a doctor once a month and has been hospitalized twice in the last three years.

Mr. Chairman, Mrs. Hawkins has absolutely no margin of safety. She cannot afford excessive inflation in health care costs. At next year's Medicare deductible level, two hospitalizations would eat up more than two months of all the income she has after she pays her rent and drug bill. And that estimate assumes she has no physician costs.

Mr. Lou Minafra is a married sixty-year old who operates a retail carpet store and is a former Republican County Chairman. His fifty-five year old wife is in ill-health. Mr. Minafra himself has been hospitalized three times in the last six years. His income is about $7,500/year. His supplemental health insurance costs $300 per month. Mr. Minafra has been able to manage the cost of his hospitalization and his wife's ill-health because of the supplemental coverage he has purchased. Paying that insurance at $300 month stretches Mr. Minafra's resources to the limit.

Mr. Chairman, Mr. Minafra cannot afford the excessive rate of health care cost increases that will send that insurance premium up at 20 percent per year or more.

Mr. Chairman, these cases are only the tip of the iceberg.

Mr. Chairman, Medicare is in difficulty, not because of excessive benefits, not because the elderly and disabled somehow abuse the program by using more services than they need, but because of the excessive inflation built into the backwards incentives of our health care system as a whole.

Mr. Chairman, it is time to cut the albatross of excessive health care cost inflation from around the necks of the Medicare program and the nation's elderly.

Just as the aged and disabled are burdened by excessive health care cost inflation, the Federal budget also suffers. The combination of the Reagan depression, voodoo economics, and excessive defense spending has been the key cause of the $200 billion deficits that stretch as far as the eye can see. Nonetheless, uncontrolled inflation in

health care costs has also made an important contribution to this disastrous budget situation.

Between 1970 and 1982, Federal health expenditures grew from $18 billion to $93 billion. In fiscal year 1983, Medicare and Medicaid—our two largest health programs—accounted for a hefty 9.4 percent of the budget—$76 billion. Because of excessive health care cost inflation, even under the Administration's 1984 budget—which proposes savage reductions in Medicare benefits and callous elimination of the disabled Americans and poor mothers and children from the Medicaid rolls—Medicare and Medicaid will grow to $132 billion by 1988—over 50 percent growth in four years—and will account for about 17 percent of budget growth between 1984 and 1988.

We have many pressing domestic health and welfare needs for which expanded funding is dictated by both prudence and humanity; needs such as education, job training, social services, and health insurance for the unemployed. Dropping scarce Federal dollars down the bottomless pit of unnecessary health care cost inflation is not one of those needs.

Mr. Chairman, the time is now to liberate our deficit-burdened Federal budget from the chains of excessive increase in health care costs.

We all know the difficulties American business faces today competing in world markets and in raising sufficient investment capital to modernize plant and equipment. What may not be so well known is the degree to which excessive inflation in health care costs contributes to these problems.

The Chrysler corporation, for example, has estimated that its health care costs add more than $600 to the price of each car the company sells. Health benefits are the fastest growing component of business costs. Even in the depths of the depression last year, private third party health expenditures, primarily financed by business-paid premiums, increased 15 percent, compared to an overall price rise of 6.2 percent. This year, premium increases of twenty to forty percent in the cost of health insurance plans are not uncommon. In addition to and above the "normal" excessive inflation in health care costs, the Medicare hospital payment reforms enacted in the last two years will shift over $19 billion in additional costs to American business and other private payors over the next five years.

Perhaps the most striking measure of the burden excessive health care cost inflation places on American business is this; in 1983 American companies will pay out an estimated $77 billion in health insurance premiums, more than they will pay out in dividends.

Mr. Chairman, the time to eliminate the burden the unnecessary, excessive, wasteful inflation in health care costs places on American business and labor is long overdue. If our economy could ever afford this excessive rate of health care cost inflation, we cannot do so today.

The bill you are considering today, H.R. 3262, which I introduced in the Senate as S. 814, is a sound basis for building the health care cost control program of the future. Congressman Shannon and Congresswoman Mikulski and I worked with a number of groups and technical experts in developing this bill. Most notably, I am grateful for the assistance of the Senior Citizens Organization and the Health Security Action Council, a coalition of 70 labor, consumer, religious, women's, civic, fraternal and farm organizations. This bill embodies key principles that will need to be a feature of any successful approach to controlling health care costs: These principles are:

First, only a comprehensive, all-payers approach to cost control can be successful. Measures that attempt to control Medicare alone or the private sector alone will lead to cost-shifting rather than cost restraint.

Second, the all-payers system must be built around incentives to providers to render care more efficiently. Loading costs on consumers is not the answer.

Third, physicians must be part of any effective cost control program. Any approach that controls hospital costs while continuing to encourage physicians, who order 70 percent of all health care, to practice sky-is-the-limit medicine will not work.

Fourth, any effective cost control system must ensure Medicare's solvency without reducing benefits or increasing taxes, and

Fifth, any successful health care cost control program should be administered by States under broad Federal guidelines.

Finally, any effective cost control program must help protect Medicare beneficiaries from the unconstrained passing on of costs above Medicare's recognized charges that is allowed under current law.

Mr. Chairman, since Congressman Shannon and Congresswoman Mikulski and I introduced this bill I have continued to refine the ideas it contains with a particular

focus on ensuring the solvency of the Medicare program. I anticipate introducing a bill incorporating these refinements in the near future. The work of your Committee in analysing the proposal you now have before you will contribute immeasurably to eventual enactment of effective health care cost control.

Mr. Chairman, the time for action is now. We cannot afford to wait. I look forward to working with this Committee as we develop a workable, effective plan to solve the national crisis of unrestrained health care cost inflation and assure the solvency of the Medicare program.

Fact Sheet—Kennedy Medicare Rescue Plan

BACKGROUND ON THE DANGER OF MEDICARE BANKRUPTCY

Health care cost the nation $322 billion in 1982, of which Medicare consumed $52 billion.

Health care as a percentage of the gross national product has risen from 5.3 percent of GNP in 1960 to 10.5 percent in 1982.

The latest Medicare Hospital Insurance (HI) Fund Trustees Report projects Medicare bankruptcy by 1990 under the most likely ("intermediate") economic assumptions.

Under more pessimistic economic assumptions, bankruptcy could come as early as 1988.

The accumulated deficit for the period 1985 to 2005 will exceed one trillion dollars under the most likely economic assumptions.

INFLATION IN THE COST OF HEALTH CARE

Year	CPI percent increase	Hospital costs percent increase	Physician costs percent increase	Health as percent of GNP
1960	1.6	11.2	3.7	5.3
1965	1.6	7.2	8.4	6.0
1970	5.9	15.4	13.4	7.5
1975	9.1	16.4	17.4	8.6
1980	13.5	16.6	16.6	9.5
1982	6.0	14.9	12.8	10.5

PRINCIPLES OF THE KENNEDY MEDICARE RESCUE PLAN

(1) No reduction in benefits.

(2) No increase in taxes.

(3) Reimbursement reforms applied to all hospital patients not just those under Medicare.

The Kennedy Plan to Eliminate the Medicare Deficit

	Billions
Cumulative Medicare Deficit (1985 to 2005)	−$1,018
Medicare Saving Under Kennedy Plan:	
I. Prospective payment system for hospitals	+426
II. Incentives to reduce unnecessary hospital admissions	+210
III. Prospective payment system for in-hospital physician services	+411
IV. Authorization for borrowing between Medicare and Social Security trust funds (not needed under the most likely economic assumptions)	
Net Surplus Under Kennedy Plan	29

THE KENNEDY PLAN ALSO PRODUCES SAVINGS FOR EMPLOYEES, EMPLOYERS, AND OTHER PRIVATE PAYERS OF HEALTH COSTS

In addition to the savings achieved under Medicare, corresponding savings will also be obtained in hospital costs in the non-Medicare sectors of the health care system.

Hospital costs will be reduced by approximately one-third.

DETAILED DESCRIPTION OF KENNEDY MEDICARE RESCUE PLAN

I. Comprehensive hospital prospective payment system.

Hospitals will be paid prospectively for each admission; payment will increase from a base period at the market basket rate (a measure of the amount hospitals pay for their goods and services) plus one percent.

The prospective payment system provides incentives to hospitals and other provides to deliver health care efficiently, and it will reward those who do so.

The prospective payment system lowers Medicare costs by reducing hospital demand for goods and services, which in turn reduces market basket prices.

The Kennedy plan also includes incentives for states to develop their own prospective payment systems under broad federal guidelines.

The plan will make additional revenues available to hospitals providing care to those who cannot afford to pay.

II. Incentives for Hospitals to Reduce Unnecessary Admissions.

Hospitals will be reimbursed at a lower rates for unnecessary admissions.

The lower rate will encourage hospitals to provide treatment on a less costly, outpatient basis where feasible and appropriate.

This type of incentive reimbursement is a current feature of virtually every mandatory state program for hospital cost containment.

III. Prospective Payment System for Hospital-Related Physician Costs.

Lump-sum payment for physician services and hospital services for each hospital patient at the market basket rate plus one percent.

Incentives for physicians and hospitals to work together to promote cost effective care.

Transfer hospital-related physician services from the Medicare Supplementary Medical Insurance (SMI) Fund to the Hospital Insurance (HI) Fund. Savings will reduce the HI Fund deficit.

IV. Interfund Borrowing Authority.

Under the most likely economic assumptions, Medicare balances will be lowest when other Social Security trust fund balances have large surpluses.

Interfund borrowing provides a safety net in the event of shortfalls in HI balances resulting from changes in estimates or unanticipated economic circumstances.

Mr. SHANNON. Senator, I want to thank you for your testimony and for your leadership on this issue.

I am convinced that, because of the very serious budget problems that we all face, that the time is right for everybody to come together on a system that will bring our health care costs under control. I think everybody has acknowledged, just as many States have already acknowledged on their own, that we can no longer continue to let the health care economy run amuck and we need to have some kind of uniform program that brings in all payors and brings in the physicians to hold costs down.

We can argue later about what we do to expand access to health care, but the first step has to be bringing the health care costs under control. I think the legislation which you introduced in the Senate and Congresswoman Mikulski and I have introduced over here is the next logical step in that direction, and I hope that we will be able to get some action on that in this Congress.

I thank you very much for your leadership.

Senator KENNEDY. Well, I thank you, Congressman Shannon.

I would hope that we would be able to really begin the debate this particular year and next year, because I am sure that members of the committee don't want to find out that we have gone through an election in which these issues have not been raised and then find out that the guillotine comes down on millions of our elderly people and elderly citizens.

I think it is important to try and lay out for both the Congress and the people the possible alternatives. For I think this administration is sweeping the issue under the rug. I see few proposals by

the administration to deal with this effectively and the only proposals they have made to date are cutting back benefits for the elderly people.

I would hope that we could begin this debate and discussion so that the elderly people are going to know what will happen to them after 1984 before 1984.

Mr. SHANNON. Well, whether we want to or not, the disastrous state of the medicare trust fund is going to force us to face up to this issue soon anyway.

I want to thank you for your contribution.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Russo?

Mr. RUSSO. Thank you very much, Mr. Chairman, and thank you, Senator.

As someone who has disagreed with you slightly on the question of hospital cost containment, basically, Senator, because of your own comment that is a part of your summary of why it is important to approve this bill, I think at least 70 percent of the health care decisions are made by people other than hospitals. As long as we allow doctors to continue ordering tests and doing things that hospitals basically have no control over other than to keep the people as patients longer, give them all the tests and increase the bill—certainly this proposal has an attraction for all of the members. Maybe those of us who felt differently about hospital cost containment need to address the entire issue of quality health care by making sure that everyone receives it.

I agree with you. I think the administration's method of addressing medicare's problems is absolutely horrifying. Other ways have to be found.

Can I ask you why you feel a means test applied to a medicare beneficiary is not proper? Why shouldn't those who have more money just like we did on social security, where we taxed those over $25,000 and $32,000, why would a means test not be proper for medicare? Those who have the money, who make $100,000 a year, why shouldn't they contribute more in copayment in return for their medicare benefits?

Senator KENNEDY. Well, basically, Mr. Chairman, I am opposed to the means test. Medicare is a compact between the elderly and the Federal Government. We say to our senior citizens you have worked hard, you have payed your taxes before retirement, and we will not now put additional provisions beteween you and the medicare coverage you have earned.

I am enormously concerned that in our society we have developed a two-criteria health care system where, on the one hand, the wealthiest individuals can get the very best and where the neediest and the poorest get a different standard. I think once we move toward means testing, we run the risk of perpetuating and housing that kind of a system, and applying it to the 29 million senior citizens and the disabled who, thanks to medicare, have largely escaped that kind of discrimination.

Finally, as the addendum I will submit illustrates, we do not need a areas test to make medicare solvent. We simply need to control the excessive health care cost inflation that has caused this problem.

Mr. RUSSO. Senator, how can we insure that when we implement the provisions of this legislation that we will guarantee quality health care to those who most need it?

Senator KENNEDY. Well, it is very difficult to give you assurance equality. There are people who have the resources to afford the best in the medical profession and still we find situations where those individuals for one reason or another do not have the correct diagnosis or the correct treatment. I think all of us are familiar with those kinds of horror stories. I am certainly familiar with them and you are.

So what you have to do in the areas of quality is to try to do the best that we can to assure the type of training, the type of peer review, the type of quality control that I think some of the best of the medical training institutions, hospitals, and medical societies have adopted. I think even with that you cannot necessarily legislate quality. I would say a great deal more has to be done within the medical profession.

Finally, I would just say that I don't think there is any question in my mind that the limitation on financial resources available to the poor and underserved increases dramatically the possibility of poor quality in our country in a very, very significant way.

Mr. RUSSO. Senator, one last question. One of the comments I hear in my workshops when I go around my district is, "Look, let's not make the same mistake that England and these other countries made where we have a health care system that is for the elite and then you have another, poorer quality health care system for the average person.

Senator KENNEDY. We are on a somewhat different issue today then national health insurance, but let me answer your question.

Canada was probably the last industrial country in the world to adopt national health insurance. They have had eight national elections since they have adopted it. You cannot name one candidate in Canada or one political party in Canada that wants to repeal health insurance. You cannot name one political candidate or find one political party in any Western democracy that has health insurance today that is trying to repeal it.

With all the problems that other countries have, and they have many, you don't have the problem of people denied care because they lack resources or people pauperized and unable to support their family because they need care they cannot pay for. You do not have what exists in just about every family of this country, with the exception of the wealthiest individuals, where people know when they get sick they are concerned about whether they are going to be able to financially support it, and what it is going to mean in terms of their children or their grandchildren or their parents because of the cost of health care. You are relieved of that kind of anxiety.

Maybe you can't put a dollar and cents figure on it, but I think it does say something about the quality of our life in our society.

Chairman JACOBS. Mr. Rangel?

Mr. RANGEL. Thank you, Mr. Chairman.

It is good to see you again, Senator. It was refreshing to hear even a discussion of national health insurance, because for the last 2½ years, people have been so jolted by the cutbacks in this admin-

istration that the poor and the aged have wondered just how many more copayments they would have and how many services would be cut in the community.

I never really knew what it was like to be a minority until I sponsored that hospital cost containment bill, and I have never seen anything tear down the heavens as speedily on the floor of the House.

Having said that, we are now moving on a bill. The bill provides, I think, that the containment of costs will be centered around putting some type of lid on the reimbursements for doctors and hospitals.

I have found in my 13 years down here that hell has no greater wrath than messing around with a doctor's compensation.

We reimburse doctors for people who become ill. The hospitals are based on the number of patients that they are able to attract.

I just wonder, when you introduce any type of legislation that attempts to deal with containing the costs of hospitals and containing the costs of physicians, how do you believe the House and Senate would be able to weather the attacks that are going to be made by the American Hospital Association and the American Medical Association?

I say this because, sadly, in all of the struggles that I have seen in the last 3 years, when it is a question as to which side you are on, services for the poor or vested interests, we have not even found the churches and the synagogues involved in this struggle.

It has just been the do-gooders losing here in the House. So it is refreshing to see that we are coming back once again to concern ourselves not only with expanding access to health care, but just as importantly, in containing care.

I wonder just what political considerations have come up that would allow you to believe that we are in better shape today then we were with the Kennedy bill, the Corman bill, the Carter bill or whatever we had?

Senator KENNEDY. Well, I would agree with your analysis, Congressman. I dare say that I felt at one time, as someone who has been involved in the issue, that it would not come to pass until it hit the middle class. Once it gets to the middle-income families—and I think it is getting there very, very rapidly—then we are going to be able to get some reaction, and, I think, some really important demands for reform.

I was always mindful of the fact that in the Vietnam war, one of the times of greatest activity was when the Congress had the draft and went to the random selection system, which picked the sons of wealthy and middle-income families. It got a good deal more attention from some of the national media, the business communities and many others than it had when it was the poor fighting in the jungles of Vietnam.

I dare say when this issue finally strikes the pocket books of middle-income families, I think we will probably have a mood and a climate where we are going to be able to take some action.

I agree with your earlier assessment about the difficulty, certainly, that we have had in the past. But there is a new factor today: Our medicare system has never faced the kind of crisis that it is going to face in the next 3 to 4 years. The deficits that we are going

to have in medicare are going to make social security look like a church picnic. And there is that recognition today.

The kind of cuts that you are going to have to talk about to even try to address these deficits—unless you go to a comprehensive cost control program—are going to be so dramatic that I dare say, that even the power and the financial contributions that are made by the American Medical Association won't be able to match the public demand for health care cost control.

It always interests me about the contributions of the AMA.

We have in our body as well as you have in yours a division between the financing of health care, which is in the Finance Committee, and the quality issues, which are in the Health and Human Resources Committee. Obviously, those issues ought to be blended in order to have a rational approach toward health care, but they are not.

But the financial contributions by the American Medical Association are always made to the Finance Committee where control over reimbursement lies and not to the Human Resources Committee.

The Human Resource Committee deals with the training of medical professionals, medical research, the whole range of nutrition programs for the citizens of the country, and the whole range of what might be considered quality of medicine issues. But that is not where the AMA contributions go. Perhaps that will change and you and I, I am sure, hope that it will.

Mr. RANGEL. Well, thank you, Senator.

Senator KENNEDY. Remembering where I am.

Mr. RANGEL. Your leadership will make it a lot easier. Thank you.

Chairman JACOBS. We thank you for your appearance here today.

Senator KENNEDY. Thank you very much.

Chairman JACOBS. The committee will be in recess until most of the members return.

[Recess.]

Chairman JACOBS. Mr. Hacking, you may proceed.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. HACKING. Thank you, Mr. Chairman.

I would like to submit the association's statement for the record.

I am Jim Hacking, assistant legislative counsel for AARP. The association has a combined membership of 14.7 million members age 50 and older. Obviously, with a membership like that, Mr. Chairman, you can imagine that medicare's financial situation and the problem of health care cost escalation are very much on our minds.

The Congressional Budget Office earlier this year projected insolvency for the HI program by 1990. Later in the year the Hospital Insurance trustees issue a report projecting insolvency by mid-1990.

At AARP's request, Mr. Robert J. Myers, an actuary who is well known to this subcommittee, produced a series of estimates or fore-

casts of HI's financial condition using assumptions that are only slightly different from those used by the HI trustees.

Under one scenario, Mr. Myers estimated what would happen to the HI fund if the alternative II-B assumptions in the 1983 trustees' report eventuated except that unit costs under the HI program increased by 12 percent in 1984 and by 15 percent per year in each subsequent year. Those are rates only slightly higher than the 13 percent annual rate that the trustees used.

Under this set of assumptions, Mr. Myers forecast that the HI fund would be exhausted by mid-1987. It should be clear that hospital reimbursement rates alone can cause a very serious acceleration of HI's impending insolvency if those rates are only slightly higher than the 13 to 14 percent annual rate of increase which has prevailed over the past 15 years.

It is apparent to AARP, and I am sure the members of this committee, that HI's financial problem is a consequence of health care cost escalation in general and hospital cost escalation in particular. The question arises, then, what is to be done?

The fact is there are only three general categories of options for dealing with HI's financial problem. The first category involves increases in hospital insurance revenue either through increases in payroll taxes on workers and their employers or through increases in taxes from other sources.

I want to make it clear that AARP is opposed to all options in this category. It makes no sense to pass more tax revenue through medicare into hospitals.

The second major category entails shifts of costs to beneficiaries. Again, AARP is opposed to all options in this category. But, for the sake of clarity, I would like to outline the basic sets of options that fall within this category. The first set entail shifts of costs to all elderly who are eligible for medicare. That could be done directly, as, for example, by imposing or increasing premiums or by means testing medicare eligibility. It can also be done indirectly, as for example, by requiring the elderly to include the value of medicare coverage in gross income for Federal income tax purposes and earmarking the increased revenue for the HI fund.

The second basic set of options within this category would shift costs, but only to those elderly who actually used medicare covered services during the course of a year. Again, this can be done directly by increasing deductibles and coinsurance, for example, or by means testing cost sharing requirements. It can also be done indirectly, as, for example, by requiring the inclusion in gross income for Federal income tax purposes of the value of medicare covered services received during the course of the year and earmarking the increased revenue for the HI fund.

To give you some example of the magnitude of the cost that would have to be shifted to medicare users in order to deal with the HI fund problem, I again want to refer to a memorandum prepared by Mr. Myers.

This memorandum presents estimates of the additional amount of cost sharing that would be required from persons receiving HI benefits in the year 1995 if such cost sharing amounts were to be sufficient to close the gap between outgo and income estimated under present law.

Mr. Myers estimated that the increased cost sharing amount in 1995 would be about $4,300 under alternative II-B assumptions and $8,200 under the trustees' alternative III set of assumptions payable on a per capita basis for persons who are actually hospitalized. This, of course, would be in addition to the inpatient hospital deductible under II-B of $800 or $1,100 under alternative III.

The third and final category——

Chairman JACOBS. Your 5 minutes has expired, Mr. Hacking.

[The prepared statement and miscellaneous material follows:]

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Thank you Mr. Chairman for the opportunity to share with this Committee the American Association of Retired Persons' views concerning the alarming crises in the health care sector of our economy and the wrenching burdens this crisis has placed on health care consumers, both young and old alike. Because this crisis is not new some have become anesthetized to the consequences of raging health care costs. AARP has not; we recognize that if health care costs, especially hospital costs, continue to escalate unabated, accessible and affordable health care will cease to be available to millions of consumers—not just the poor, but the elderly and millions of workers and their dependents too.

AARP's testimony today focuses first on the growing problem in the health care sector; its impact on Medicare and AARP's policy proposals to fashion a more rationale health system. We conclude the testimony with a brief analysis of the Health Care Cost Containment Act of 1983.

THE GROWING PROBLEMS OF THE HEALTH CARE SECTOR

The health care industry is one of the nation's largest and fastest growing economic sectors. Since 1967, health spending has increased over 12 percent per year while the economy as a whole has grown at only 9.0 percent per year. Health care spending is taking a larger share of the nation's total resources—rising from 6.4 percent of GNP in 1967 to 10.5 percent in 1982.

Despite the sharp decline in inflation throughout other sectors of the economy in 1982, health care costs continued to escalate at unacceptable rates; up 12.5 percent from 1981 compared to only a 4 percent inflation rate for the economy as a whole. Hospital expenditures were the largest component of spending ($135 billion in 1982), 40 percent of all health care expenditures for the year.

Cost plus reimbursement of services under Medicare as well as private industry plans has been one of the most important factors fueling the growth of the health industry. Under this system, reimbursement is retrospective, based on the number of services provided—physicians receive a fee for each service provided; hospitals are reimbursed according to costs incurred for providing services. Therefore, the more services given, the more money received. Unlike purchasing other goods and services, physicians rather than consumers make nearly all the decisions about health care—allowing the consumer little or no leverage over the prices paid for health services.

Such a system is inherently inflationary. It rewards providers with more and more income for giving more and more care, and for acquiring more and more costly, technically sophisticated plant and equipment, whether it is necessary and beneficial or not. Moreover, because reimbursement favors institutional care, physicians overutilize hospitals, the most expensive component of medical care.

Government has encouraged growth of the third-party payment system through its tax laws. Both employer and employee health insurance premium payments are excluded from taxable income. In addition to this insurance subsidy, Blue Cross/Blue Shield plans are tax exempt in most states. Government subsidies to increase the supply of medical services have also influenced the rate of growth in health spending. Hospital expansion has been stimulated by the Hill-Burton program (a government program that provided funds for hospital construction) and by the tax-exempt status of hospital construction bonds. The supply of health professionals has been stimulated by billions of dollars in federal spending for health education and training.

MEDICARE

The rapid escalation in health care costs in general and hospital costs in particular has been driving up the costs of Medicare. Over the last five years, Medicare expenditures have increased at an average rate of 18 percent per year. In 1982, Medicare expenditures totaled $50 billion, up 17.6 percent since 1981.

The rapid growth in Medicare expenditures, combined with other adverse economic circumstances, are taking their toll on the Hospital Insurance (HI) trust fund. The Congressional Budget Office (CBO) projects that the fund's reserves will be exhausted by 1990. That means the fund will be unable to pay hospital claims on time and therefore, be technically insolvent. Most alarming of all, however, is the recognition that HI's problems are not just short term. Unless drastic action is taken to reduce the projected rate of growth in HI expenditures, even the more favorable economic and demographic conditions expected in the 1990's will not prevent the program from accumulating an even larger deficit over time.

Although the crux of the Medicare shortfall is in the HI trust fund, expenditures are also rapidly rising in the Supplementary Medical Insurance fund (Part B). Because three-fourths of Part B is financed by general revenues, it is not in danger of bankruptcy. However, to meet its projected demands, CBO projects that $31.9 billion in general funds will be needed in 1988, compared to $14.2 billion this year, a 225 percent increase in just four years.

Over the past three years Congress has enacted Medicare cuts totalling $25 billion through 1986 in an attempt to reduce Medicare's financial burden. To date, spending reductions in Medicare have been achieved through specific program changes, either by increasing beneficiaries' out-of-pocket payments (Part A and B deductibles and coinsurance) or by limiting the amount which only Medicare pays to hospitals and physicians. Achieving budget savings solely within the parameters of Medicare, however, has little long run impact on the escalation of Medicare costs.

With three quarters of Medicare expenditures spent on hospital care, rising hospital costs are the prime contributor to Medicare's financial problems. Because hospital costs are escalating at twice the rate of the payroll taxes financing the HI trust fund, HI costs are projected to exceed its income by approximately $20 billion per year, accumulating a $300 billion deficit by 1995. Clearly, restraints on hospital costs are needed to stabilize Medicare expenditures and restore solvency in the HI trust fund. Without such action, Medicare benefits will be drastically cut requiring beneficiaries to pay substantially larger amounts out-of-pocket for health care. If that happens, more and more of the elderly will find themselves unable to afford needed health care services.

AARP'S PROPOSALS

AARP advocates a comprehensive approach to health care cost containment which focuses on negotiating—or, if necessary, mandating—limits on the rate of increase in payments to providers, especially hospitals, for all third-party payors, not just Medicare.

Experience has shown that cost-containment proposals limited solely to Medicare (e.g., benefit reductions or changes in Medicare's reimbursement mechanism) do little to reduce the overall rate of increase in hospital and other health care costs. Such solutions accept the rapid increases in hospital and health care costs as a given and merely change who pays for what. Channeling even more resources into hospitals, either by requiring Medicare beneficiaries to pay more or by increasing payroll taxes on employees and employers, will not solve the problem of rapidly rising Medicare and hospital costs.

Although AARP recognizes the recently enacted Medicare prospective payment plan as a step in the right direction, it limits only Medicare payments to hospitals. Because of the potential for hospitals to charge higher rates to other private and third-party payors in order to regain revenue lost from reduced Medicare payments, it will have little or no impact on controlling total hospital spending.

AARP supports legislation that would encourage the states to adopt mandatory hospital rate review programs to assure that increases in payments to hospitals do not exceed the national limit and also to control the growth and expansion of hospital facilities. In the six states currently running mandatory hospital rate review programs, hospital cost increases, on average, have been 3 percent below those states without mandatory programs. If all states had similarly restrained increases in hospital costs, it is estimated that nationwide hospital expenditures would have been $12 billion less in 1981.

Physicians fees, on average, have been increasing at a rate of 50 percent greater than the rate of inflation since 1975. Coupled with caps on hospital payments,

AARP supports restrictions on physician fees in order to reduce this rapid rate of increase.

Caps on providers' payments are necessary in the short-term to "free-up" resources for less costly and appropriate alternatives to institutional care. Over the long run, AARP believes that regulation should gradually give way to more market-oriented solutions which promote competing forms of health care delivery such as HMOs, small clinics, and ambulatory health care facilities of all kinds.

THE HEALTH CARE COST CONTAINMENT ACT OF 1983

The Health Care Cost Containment Act of 1983, H.R. 3261, is a tough regulatory approach to stopping the unwarranted increases in health care costs. The legislation includes three major principals which are essential for a successful cost control program:

(1) it applies to all payors, not just Medicare and Medicaid;

(2) it allows states the flexibility to design their own cost control systems within broad federal guidelines; and

(3) it provides a procedure for setting maximum physician fees.

These principals are consistent with long standing AARP policy proposals. They are important because:

(1) All payors—recognizes the necessity of controlling all third-party payments to avoid cost shifting, maintains the national commitment to a high quality, single tier system, and it treats payors equally.

(2) State flexibility—within broad federal guidelines, provides opportunity to control costs at the level of government with the greatest understanding of local circumstances and unique state interests. Moreover, state rate programs have been successful at reducing health care costs!

(3) Maximum physician fees—controls rapidly escalating source of costs and the most important decision makers in the delivery system.

H.R. 3261 provides a two phase approach to controlling costs. Phase I limits the rate of increase in hospital revenues from all sources. Limiting hospital revenues, rather than establishing per diem or per case rates, creates less incentive for hospitals to circumvent the system by increasing admissions and length of stay. Programs limiting total revenues, however, must closely monitor hospital revenues for compliance. The looser the monitoring the longer the lag between receipts and compliance, the more difficult it is to control hospital costs. In contrast, setting payment rates affects a hospital's cash flow immediately and, thereofre, affects costs immediately.

AARP does *not* find the Phase I formula defining the permissible rate of increase in hospital revenues to be unreasonable, including the tightening of Medicare payments called for by H.R. 3261. Perhaps the most controversial element of the legislation is the controlling of physician fees and the charges associated with outpatient services. The bill establishes a maximum permissible rate of increase for physician fees designed to allow physicians to recoup increased expenses due to inflation in the cost of overhead and goods and services. In essence, the bill mandates assignment!

While AARP recognizes the philosophical and practical difficulties inherent in such a step, the harsh reality of uncontrolled physician fees leaves cost weary patients no other choice. As educated and skilled as most physicians are, we can no longer permit them to continually boost their incomes well beyond the incomes of other educated and skilled professionals simply because of the eccentricities of the health care market. The amount of public moneys supporting basic medicine, medical education and research manifests a broad public commitment to the health professions. The public expects a commensurate commitment by health professionals to the integrity of an accessible, affordable health care system. That commitment has been lacking. Hence, mandatory assignment provides the only means by which the public can ensure access to affordable physician care.

Phase II of the legislation focuses on state cost containment programs. States are given broad flexibility in designing and implementing their own cost containment system. The basic guidelines closely follow the TEFRA requirements for states to establish their own systems. In addition, H.R. 3261 provides a 2 percent increase in state Medicaid reimbursement for those states operating an approved cost containment program. AARP supports such initiatives believing that states should be encouraged to set-up and operate such mechanisms.

CONCLUSION

Health care cost containment is the most important domestic policy issue facing this nation. H.R. 3261 provides the kind of across-the-board approach that is required to slow costs and ensure a stable, affordable health care delivery system.

AMERICAN ASSOCIATION OF RETIRED PERSONS,
October 11, 1983.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means,
U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Unfortunately, time expired before I was able to complete my remarks at the Subcommittee's September 28th hearing with a clear and unequivocal endorsement of H.R. 3261, the Health Care Cost Containment Act of 1983. This legislation falls squarely within the third and final category of options available for dealing with Medicare's financial problem that I was about to describe when my allotted time expired.

AARP believes that H.R. 3261 represents an effective approach to containing the principal elements of health care cost escalation. The imposition of limits on providers' revenue and fees, plus the creation of incentives for states to undertake health care cost containment initiatives, are essential components of the machinery needed to control runaway health care costs.

Moreover, AARP believes that controlling health care costs, particularly hospital costs, is an immediate necessity. AARP believes that H.R. 3261, or legislation like it, must be put on the statute books immediately. We must control costs now. The pending insolvency of the HI Trust Fund requires immediate action. We are confident that HHS could administer H.R. 3261, should it become law.

AARP commends you for your leadership in presenting effective measures to slow health care cost escalation. We look forward to working with you, Congressman Shannon, and other members of the Subcommittee to obtain approval of effective, across-the-board cost containment legislation.

As a final matter, I respectfully request that a copy of this letter be included as part of AARP's submission for the record of the September 28th hearing. I also wish to have the attached copies of Mr. Robert Myers' memoranda included, since I made reference to them in my remarks before the Subcommittee.

Sincerely,

JAMES M. HACKING,
Assistant Legislative Counsel.

Enclosures.

ROBERT J. MYERS,
Silver Spring, Md., September 20, 1983.

Memorandum.

Subject: Effect On Trust Fund Balances of "Worst-Case" Hospital Reimbursement Assumptions.

This memorandum will present an estimate of what would happen to the HI and combined OASDI-HI trust funds if the Alternative II-B assumptions in the 1983 Trustees Report eventuated except that unit costs under the HI program followed a "worst-case" scenario. Such a scenario would be that unit costs would increase by 12 percent in 1984, and by 15 percent per year in each subsequent year.

Under these assumptions, the HI Trust Fund would be exhausted in mid-1987 (as compared with mid-1990 under the Alternative II-B assumptions for all factors).

Considering the combined OASDI-HI trust funds (which, in essence, would present a picture of financial solvency if permanent inter-fund borrowing were permitted), the positive balance of about $35–40 billion is maintained through 1986, but thereafter there is a rapid decrease, and a negative balance occurs in late 1989. On the other hand, under the Alternative II-B assumptions for all factors, the combined balance of the trust funds increases steadily throughout the 1980s—and, in fact, in all years thereafter for at least the next two decades (the financing problem coming only after the trust funds are adversely affected by the World War II baby boomers reaching retirement age).

In summary, although there may be those who argue that the combined OASDI-HI system will be financially sound for at least the next three decades, this memorandum shows that hospital reimbursement rates alone can cause a serious financial problem before 1988 if they are at a slightly higher level than the 13–14 percent annual increases which have prevailed in the past 15 years.

FUND BALANCES AT END OF YEAR FOR HI TRUST FUND AND FOR COMBINED OASDI–HI TRUST FUNDS UNDER "WORST-CASE" HOSPITAL-REIMBURSEMENT ASSUMPTIONS, 1983–90

[In billions]

Year	Alternative II–B	Worst-Case Assumptions
HI Trust Fund:		
1983	$24.1	$24.1
1984	23.1	22.3
1985	22.1	17.3
1986	22.6	8.8
1987	21.0	−8.8
1988	16.1	−38.7
1989	7.8	−83.7
1990	−4.9	−148.2
Combined OASDI–HI Trust Fund: [1]		
1983	39.2	39.2
1984	38.8	38.0
1985	42.7	37.9
1986	47.9	34.1
1987	52.3	21.5
1988	70.0	15.2
1989	90.2	−1.3
1990	118.6	−24.7

[1] Does not allow for effect of normalized-tax procedure for OASDI Trust Funds which results in a significant increase at the beginning of each month (to meet the outgo peak occurring then).

ROBERT J. MYERS,
Silver Spring, Md., September 23, 1983.

Memorandum.

Subject: Additional Cost Sharing Needed in 1995 to Balance Excess of Outgo over Income under HI Program.

This memorandum will present estimates of the additional amount of cost sharing that would be required from persons who receive HI benefits in 1995 if such cost-sharing amounts were to be sufficient to close the gap between outgo and income estimated under present law. The estimates of the additional cost-sharing amounts are made under two bases—the Alternative II-B assumptions and the Alternative III assumptions of the 1983 HI Trustees Report.

As a matter of background, it is estimated that the initial deductible (which is $304 in 1983 and will probably be $356 in 1984) is estimated for 1995 to be about $800 under Alternative II-B and $1,100 under Alternative III. Part of these significant increases is due to the rises in the general level of prices and the remainder is due to the additional increases in hospital costs over the general price level.

Under Alternative II-B, it is estimated that the increased cost-sharing amount (however derived) for 1995 will be about $4,300 under Alternative II-B and $8,200 under Alternative III, payable on a per capita basis for persons who are hospitalized (i.e., not spread over the entire group of eligible beneficiaries). It might be mentioned that the estimated gap of outgo over income in 1995 is about $39 billion for Alternative II-B and $78 billion for Alternative III.

The CBO has presented an estimate of a somewhat similar nature in its memorandum "Prospects for Medicare's Hospital Insurance Trust Fund" (February 1983). It would appear that its estimate that assumes extension of the reimbursement limits in TEFRA is relatively pessimistic, although not quite as much so as Alternative III. This memorandum shows a gap between outgo and income in 1995 of about $63 billion, and a necessary cost-sharing amount per person hospitalized to close this gap of about $6,900.

ROBERT J. MYERS.

Chairman JACOBS. Who on the panel wishes to speak next?
Ms. TARR-WHELAN. I will be glad to.

STATEMENT OF LINDA TARR-WHELAN, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL EDUCATION ASSOCIATION

Ms. TARR-WHELAN. Good morning, Mr. Chairman. I am Linda Tarr-Whelan speaking for the National Education Association, representing 1.7 million teachers, higher education faculty, and education support personnel, and we appreciate this opportunity to testify in favor of H.R. 3261.

I ask that my statement be submitted for the record, and I will give a short summary of that.

We are concerned about this issue for two reasons: (1), in terms of our members who are consumers of health-care; and second, our clients, the 45 million students in public schools across the country who are also consumers.

With regard to our membership, health care costs are really a substantial burden to them. The average teacher's salary in public schools last year was $19,157. In 30 States, the average is below that amount. While our members receive health-care coverage to a fairly large degree, 97 percent of them have health-care coverage, only 75 percent have any kind of dental care. Less than 50 percent have vision screening, and in a recent survey of our members, a third noted that they were unsatisfied with their current coverage.

Family benefits are available under contracts only on an out-of-pocket basis to our members. In many small school districts where there are less than 12,000 enrolled pupils, health care coverage for married women is specifically excluded in contracts—something we are trying to take care of.

Among retired teachers, the situation is quite grim because only one in four has hospital insurance coverage provided by the employer as compared to 68 percent of private retirees.

We believe that there are some wrong solutions being proposed to this particular problem. Three of the common approaches which we see across the country are: first of all, changing carriers, which is normally always a way of reducing benefits or coverage; second, changing deductibles, and that is always increasing deductibles; and third, is bargaining copayment provisions in which employees take up more of the costs in order to hold down the employer's premiums.

We are also beginning to see something else arising as a solution, which we think is inadequate and why we are supporting a legislative solution.

In the State of Kentucky, there is a new State health insurance contract which will require more than 88,000 teachers and other employees of the schools in Kentucky to receive approval from Kentucky Blue Cross before being admitted to a hospital for nonemergency treatment. This contract further requires that a long list of surgical procedures including tonsillectomies, hemorrhoidectomies and D&C's must be performed only on an outpatient basis, preferably in a doctor's office, or will not be covered by the insurance.

Our members are very concerned about this extraordinary approach to cost containment. It is also our concern this we will see proposals like that arise in other places.

It is therefore our conviction that the only sensible approach to the problem is a legislative one. The answer lies beyond the authority of the hospital, and the doctor, and the manufacturer of medical equipment and pharmaceuticals.

The entire system needs a control mechanism that will accomplish three strategic and interlocking tasks. (1) to assure that each patient receives the most appropriate and timely medical care; (2) to deliver that care in a cost-effective manner; and (3) to maintain and improve the quality of services offered.

We believe that the proposal, H.R. 3261, establishes a climate in which all three of these objectives can be obtained without undue hardship on the part of the patient or provider. We feel the bill has some unique creativity and ingenuity in terms of the negotiation process for devising payment schedules and we also feel very strongly that the advisory committee, which is listed for health care, and technologies, and procedures, is a very wise step.

We would ask only one additional consideration, Mr. Chairman, and that is because we believe that prevention is a critical part of cost containment. We would like consideration of this committee of the whole situation of well-child care.

A good beginning has been made in some school districts across the country, but the budget crisis has forced many schools to lay off their school nurses or to leave that item to a low-priority level.

We believe the legislation should address the opportunity for improving health education, well-child care, and emergency services in the schools with appropriate funding for some pilot programs in a variety of situations—urban ghetto, suburban and rural—to see if we can't deal with that particular issue.

Mr. Chairman, the National Education Association is standing by to assist this committee in the passage of this important legislation.

Thank you.

[The prepared statement follows:]

STATEMENT OF LINDA TARR-WHELAN, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL EDUCATION ASSOCIATION

Mr. Chairman and Members of the Subcommittee: The National Education Association, which represents 1.7 million teachers, higher education faculty and education support personnel, appreciates this opportunity to testify in support of HR 3261, the Health Care Cost Containment Act of 1983. I am Linda Tarr-Whelan, Director of Government Relations.

DIMENSIONS OF THE PROBLEM

NEA's concern with this issue stems from two bases. Our members are consumers of health care. And our clients—the students of all ages in every part of the nation—are also consumers. As such, our members and those whom they serve are rightly worried about the continuing, relentless escalation of medical care costs. Generally accepted estimates of the total personal health care bill for 1982 indicate expenditures of $287 billion—an increase of 12.5 percent over 1981, more than twice the 6.1 percent increase in the general Consumer Price Index. These increases have been persistent over the past decade despite the voluntary effort launched by the hospitals several years ago and the various strategies attempted by the insurance industry.

We know that health insurance coverage is anything but universal, despite the fact that the vast majority of working people and their families have some kind of coverage. There are still 35 million Americans who have no health coverage and who are beyond the reach of the Medicare and Medicaid programs. To this population group, the high cost of hospital care is a catastrophic burden. To these people,

the cost of a visit to a doctor's office is such that only crisis care is sought. To these people, the cost of prescription drugs is a significant budget problem, one which may lead to the use of over-the-counter remedies that may be inappropriate or harmful, even life-threatening.

Within our membership, high health care costs are a substantial burden. The average teacher salary in the public elementary and secondary schools last year was $19,157, but in 31 states the average salary is below that amount. The state averages begin at $14,000, with entry level pay scales far below the averages. Teacher salary increase ranged from 1.4 percent to 14 percent, with an average of 7.5 percent. Teachers in 28 states received less than that amount. Education support personnel are even worse off. The ability of our members to pay the high price of medical care is severely limited.

Health insurance coverage is available to 97 percent of our members, but only 75 percent have some kind of dental care, and less than 50 percent have vision screening coverage. Within this group, family benefits are available on a limited bases—almost always out-of-pocket to our members. And in many small school districts—those enrolling less than 12,000 pupils—health care coverage is specifically excluded in contracts for married women. Some relevant statistics on NEA members and their coverage are attached to this statement.

Among retired teachers, we know that only one in four has hospital insurance coverage provided by the employer. Private industry retirees fare much better—about 68 percent are covered by some kind of health insurance provided by the employer. Because hospitalization is more frequent among older and retired workers, teachers often face severe economic hardship in their retirement years because their expenses are not covered.

In just a decade, health care costs have risen from seven percent of our gross national product to 10.5 percent. Certainly the time is ripe for full Congressional attention to this increasingly urgent national problem.

Unfortunately, a number of solutions being offered are less than satisfactory. One is the so-called "pro-competition" approach in legislation such as HR 850, under which each consumer would be offered a choice among competing plans for health insurance and health care delivery. Governments and employers would be required to offer each consumer a fixed-dollar subsidy toward the purchase of coverage by any of the competitors. In a 1982 statement on this kind of legislation, NEA pointed out the fallacy of assuming that consumers, if given a choice, would make knowledgeably and economically rational choices that would result in better insurance and provider behaviour. If one is able to shop around at all for medical services, the choice will tend to be made on a limited judgment of what might be most effective, not on what would be cheapest. And in shopping for insurance, consumers who are young and healthy would tend to choose limited (low-cost) coverage; workers who are older or in poor health would probably choose comprehensive (high-cost) coverage. As a result of how insurance companies set premium rates, high-option premiums would go through the roof. And still the problem of hospital and physician fees would not be addressed.

WRONG SOLUTIONS

At the state and local level, there seem to be as many schemes for cost containment as there are insurance agents selling them and school boards negotiating them. The three most common approaches are simple, but each serves to shift health care costs onto the employees.

(1) Changing carriers.—In this most prevalent approach, the end result is almost invariably a reduction in benefits or coverage.

(2) Changing deductibles.—By increasing the deductible for major medical coverage from, say, $100 to $200, the premium is reduced but each employee is required to pay an additional $100 before the treatment is covered.

(3) Bargaining copayment provisions.—In this common approach, employees take up more of the cost in order to hold down employer premiums. In effect, this scheme reduces the employer's liability for premium payments.

Let me cite another poor solution. Just the other day it came to our attention that a new state health insurance contract in Kentucky will require more than 88,000 teachers and other employees to receive approval from Kentucky Blue Cross before being admitted to a hospital for non-emergency treatment. This contract further requires that a long list of surgical procedures—including tonsillectomies, hemmorhoidectomies, and dilation and curettage—must be performed on an outpatient basis, preferably in doctors' offices, if they are to be covered. NEA members in Kentucky are understandably upset by this extraordinary approach to cost containment—the

more so because they were not consulted in advance about the provisions of the contract. They are experiencing difficulty in securing Blue Cross payment of their bills. A requirement to obtain a second opinion before any surgical procedure is performed was not explained to them ahead of time, and the processing of claims is being held up all around the state. And the worst feature of the outpatient surgery requirement is that there are only two centers in the state that are adequately equipped and staffed to perform the services safely and efficiently.

GETTING AT THE PROBLEM

It is our conviction that the only sensible approach to the problem is a legislative one. Insurance serves as a buffer to the individual and the family, but it does not address the fundamental issue: the demand for medical services is not created by the consumer, but by the medical profession itself. Hospitals in our society have no control over the extent to which their services are used; it is the physician who admits the patient, determines which tests will be run, and what procedures will be used in treatment. The physician is not part of the management team or the directorate of the hospital, but the work of the hospital is directly controlled by the independent practitioner. This is not to say that the doctors alone bear the responsibility for cost escalation. But they contribute to it in the absence of a rational plan to counteract it.

The answer lies beyond the authority of the hospital and the doctor and the manufacturer of medical equipment and pharmaceuticals. The entire system needs a control mechanism that will accomplish these strategic and interlocking tasks:

(1) To assure that each patient receive the most appropriate and timely medical care;

(2) To deliver that care in a cost-effective manner; and

(3) To maintain and improve the quality of services offered.

Mr. Chairman, we believe that HR 3261 establishes a climate in which these three objectives may be attained, without undue hardship on the part of patient or provider.

In the years since Congress rejected hospital cost containment legislation, the nation's medical bill has risen $98 billion—$50 billion in hospital costs alone. States have begun to recognize the need to protect their citizens against this runaway inflation, and several—New Jersey, New York, Maryland, and Massachusetts, to single out a few—have adopted new approaches based on prospective budgeting and budget reviews. Congress has taken a promising first step in enacting the diagnostic-related group (DRG) approach to Medicare reimbursement, and with careful review and refinement procedures this strategy can help restrain the rising costs of health care. HR 3261 builds on the promising initiatives developed by the states and, in fact, encourages state creativity and ingenuity by allowing them to devise payment systems to meet unique state and local needs.

HR 3261 also recognizes that hospital costs are only part of the problem—that the growth of physicians fees, lab tests, and other procedures is also greater than the general rate of inflation. The bill provides that in state cost containment systems maximum fee schedules shall be established, but by a process of negotiation that involves the physicians as well as the consumers. This process will allow fair consideration of the legitimate concerns of health care providers, and we applaud the drafters of this legislation for their sensitivity to the fairness issue—without which any legislated remedy will surely fail.

We are also pleased that the legislation establishes an Advisory Committee on Health Care Technologies and Procedures. Drawn from distinguished leaders in medicine, engineering, the sciences, and health care-related business fields, the Committee would also include members of the general public who represent the interests of the consumers of health care. The functions of this body would be prioritized, giving close attention to the utilization, cost, and efficiency or expensive treatment. We believe it is equally important for this panel to consider appropriate standards for preventing as well as therapeutic programs.

Because our members are in daily contact with children, they know the importance of well-child care, which can be implemented very efficiently in the school setting. A good beginning has been made in many school districts, but the budget crisis facing the schools has too often relegated these services to a low priority. And where these services have survived the budget crunch, the emphasis is mainly on crisis intervention. The legislation should address the opportunity for improving health education, well-child care, and emergency services in the schools, with appropriate funding for pilot programs in a variety of situations—urban, ghetto, suburban, and rural.

Mr. Chairman, we are convinced that the passage of HR 3261 is of critical importance in advancing the economic health of the nation as well as the physical health of the people. It is long overdue. The opportunities for extending and improving the health care system are sufficient reason for acting now, but it is clear than any further delay in developing a viable cost contain ment mechanism will invite catastrophe. We urge this Committee to approve HR 3261 in this session.

Thank you.

ATTACHMENT I

nea
RESEARCH
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Rankings of the States, 1983

Selected Tables

C-13. ESTIMATED AVERAGE SALARIES OF PUBLIC SCHOOL TEACHERS, 1982-83

1. ALASKA	$33,993
2. DIST. OF COL.	26,048
3. NEW YORK	25,100
4. HAWAII	24,796
5. MICHIGAN	23,965
6. CALIFORNIA	23,935
7. WYOMING	23,690
8. WASHINGTON	23,413
9. RHODE ISLAND	23,175
10. MARYLAND	22,786
11. ILLINOIS	22,618
12. MINNESOTA	22,296
13. WISCONSIN	21,866
14. NEW JERSEY	21,642
15. COLORADO	21,470
16. OREGON	21,301
17. PENNSYLVANIA	21,000
18. NEVADA	20,944
19. UTAH	20,926
20. CONNECTICUT	20,795
21. DELAWARE	20,625
UNITED STATES	20,603
22. NEW MEXICO	20,600
23. ARIZONA	20,170
24. INDIANA	20,067
25. OHIO	20,004
26. TEXAS	19,569
27. MONTANA	19,463
28. LOUISIANA	19,265
29. MASSACHUSETTS	19,000
30. IOWA	18,990
31. VIRGINIA	18,707
32. KENTUCKY	18,400
33. NORTH DAKOTA	18,390
34. FLORIDA	18,380
35. OKLAHOMA	18,240
36. KANSAS	18,231
37. ALABAMA	17,850
38. NORTH CAROLINA	17,836
39. IDAHO	17,549
40. MISSOURI	17,493
41. TENNESSEE	17,425
42. GEORGIA	17,412
NEBRASKA	17,412
44. WEST VIRGINIA	17,322
45. SOUTH CAROLINA	16,430
46. MAINE	15,772
47. SOUTH DAKOTA	15,595
48. NEW HAMPSHIRE	15,353
49. VERMONT	15,338
50. ARKANSAS	15,029
51. MISSISSIPPI	14,323

NEA Research, unpublished data.

C-14. ESTIMATED AVERAGE SALARIES OF PUBLIC SCHOOL TEACHERS AS A PERCENT OF NATIONAL AVERAGE, 1982-83

1. ALASKA	164.80
2. DIST. OF COL.	126.43
3. NEW YORK	121.83
4. HAWAII	120.35
5. MICHIGAN	116.32
6. CALIFORNIA	116.17
7. WYOMING	114.98
8. WASHINGTON	113.64
9. RHODE ISLAND	112.48
10. MARYLAND	110.60
11. ILLINOIS	109.78
12. MINNESOTA	108.22
13. WISCONSIN	106.13
14. NEW JERSEY	105.04
15. COLORADO	104.21
16. OREGON	103.39
17. PENNSYLVANIA	101.93
18. NEVADA	101.66
19. UTAH	101.57
20. CONNECTICUT	100.93
21. DELAWARE	100.11
UNITED STATES	100.00
22. NEW MEXICO	99.99
23. ARIZONA	97.90
24. INDIANA	97.40
25. OHIO	97.09
26. TEXAS	94.98
27. MONTANA	94.47
28. LOUISIANA	93.51
29. MASSACHUSETTS	92.22
30. IOWA	92.17
31. VIRGINIA	90.80
32. KENTUCKY	89.31
33. NORTH DAKOTA	89.26
34. FLORIDA	89.21
35. OKLAHOMA	88.53
36. KANSAS	88.49
37. ALABAMA	86.64
38. NORTH CAROLINA	86.57
39. IDAHO	85.18
40. MISSOURI	84.91
41. TENNESSEE	84.58
42. GEORGIA	84.51
NEBRASKA	84.51
44. WEST VIRGINIA	84.08
45. SOUTH CAROLINA	79.75
46. MAINE	76.55
47. SOUTH DAKOTA	75.69
48. NEW HAMPSHIRE	74.52
49. VERMONT	74.45
50. ARKANSAS	72.95
51. MISSISSIPPI	69.52

Computed from NEA Research, unpublished data.

C-15. PERCENT INCREASE IN AVERAGE SALARIES OF PUBLIC SCHOOL TEACHERS, 1972-73 TO 1982-83

1. WYOMING	154.90
2. UTAH	146.22
3. NEW MEXICO	136.37
4. KENTUCKY	136.02
5. HAWAII	135.46
6. OKLAHOMA	134.83
7. ALASKA	131.56
8. IDAHO	129.19
9. NORTH DAKOTA	128.39
10. TEXAS	125.42
11. OREGON	123.05
12. COLORADO	122.12
13. WASHINGTON	121.07
14. ALABAMA	120.23
15. RHODE ISLAND	118.51
16. LOUISIANA	118.00
17. MONTANA	117.49
18. DIST. OF COL.	114.79
19. KANSAS	114.36
20. WEST VIRGINIA	113.88
21. MINNESOTA	111.28
22. TENNESSEE	109.99
23. WISCONSIN	109.97
24. OHIO	107.77
25. MISSISSIPPI	107.34
26. SOUTH CAROLINA	105.27
27. ARKANSAS	104.95
28. MARYLAND	104.19
29. NEW YORK	103.09
UNITED STATES	102.47
30. PENNSYLVANIA	102.14
31. MICHIGAN	101.78
32. GEORGIA	100.48
33. ARIZONA	100.44
34. NEBRASKA	100.05
35. INDIANA	99.73
36. ILLINOIS	99.44
37. FLORIDA	98.70
38. SOUTH DAKOTA	98.41
39. CALIFORNIA	98.27
40. IOWA	97.87
41. VIRGINIA	96.68
42. NORTH CAROLINA	96.43
43. CONNECTICUT	96.11
44. DELAWARE	94.70
45. MISSOURI	93.10
46. NEVADA	92.78
47. NEW JERSEY	84.36
48. MASSACHUSETTS	80.63
49. MAINE	79.69
50. VERMONT	72.98
51. NEW HAMPSHIRE	67.66

Computed from NEA Research, unpublished data.

C-19. ESTIMATED AVERAGE SALARIES OF INSTRUCTIONAL STAFF IN PUBLIC SCHOOLS, 1982-83

1. ALASKA	$34,510
2. CALIFORNIA	27,593
3. DIST. OF COL.	26,922
4. NEVADA	26,412
5. NEW YORK	25,600
6. HAWAII	25,423
7. WASHINGTON	24,470
8. WYOMING	23,820
9. MARYLAND	23,773
10. MICHIGAN	23,744
11. RHODE ISLAND	23,600
12. ILLINOIS	23,347
13. MINNESOTA	23,313
14. MASSACHUSETTS	23,000
15. UTAH	22,768
16. NEW JERSEY	22,684
17. WISCONSIN	22,356
18. COLORADO	22,291
19. ARIZONA	22,000
20. PENNSYLVANIA	21,800
21. CONNECTICUT	21,770
UNITED STATES	21,671
22. OREGON	21,460
23. DELAWARE	21,333
24. NEW MEXICO	21,168
25. INDIANA	20,873
26. OHIO	20,730
27. MONTANA	20,150
28. TEXAS	20,092
29. LOUISIANA	19,749
30. FLORIDA	19,605
31. IOWA	19,538
32. VIRGINIA	19,492
33. KENTUCKY	19,230
34. KANSAS	19,169
35. SOUTH CAROLINA	18,980
36. OKLAHOMA	18,870
37. NORTH DAKOTA	18,830
38. NEBRASKA	18,488
39. ALABAMA	18,450
40. NORTH CAROLINA	18,327
41. GEORGIA	18,282
42. IDAHO	18,229
43. MISSOURI	18,216
44. WEST VIRGINIA	18,054
45. TENNESSEE	17,743
46. SOUTH DAKOTA	16,493
47. MAINE	16,205
48. NEW HAMPSHIRE	15,616
49. ARKANSAS	15,549
50. VERMONT	15,003
51. MISSISSIPPI	14,824

NEA Research, unpublished data.

C-20. ESTIMATED AVERAGE SALARIES OF INSTRUCTIONAL STAFF AS PERCENT OF NATIONAL AVERAGE, 1982-83

1. ALASKA	159.25
2. CALIFORNIA	127.14
3. DIST. OF COL.	124.23
4. NEVADA	121.88
5. NEW YORK	118.13
6. HAWAII	117.31
7. WASHINGTON	112.92
8. WYOMING	109.92
9. MARYLAND	109.70
10. MICHIGAN	109.57
11. RHODE ISLAND	108.90
12. ILLINOIS	107.73
13. MINNESOTA	107.58
14. MASSACHUSETTS	106.13
15. UTAH	105.06
16. NEW JERSEY	104.67
17. WISCONSIN	103.16
18. COLORADO	102.86
19. ARIZONA	101.52
20. PENNSYLVANIA	100.60
21. CONNECTICUT	100.46
UNITED STATES	100.00
22. OREGON	99.03
23. DELAWARE	98.44
24. NEW MEXICO	97.68
25. INDIANA	96.32
26. OHIO	95.66
27. MONTANA	92.98
28. TEXAS	92.71
29. LOUISIANA	91.13
30. FLORIDA	90.47
31. IOWA	90.16
32. VIRGINIA	89.95
33. KENTUCKY	88.74
34. KANSAS	88.45
35. SOUTH CAROLINA	87.58
36. OKLAHOMA	87.07
37. NORTH DAKOTA	86.89
38. NEBRASKA	85.31
39. ALABAMA	85.14
40. NORTH CAROLINA	84.57
41. GEORGIA	84.36
42. IDAHO	84.12
43. MISSOURI	84.06
44. WEST VIRGINIA	83.31
45. TENNESSEE	81.87
46. SOUTH DAKOTA	76.11
47. MAINE	74.78
48. NEW HAMPSHIRE	72.06
49. ARKANSAS	71.75
50. VERMONT	69.23
51. MISSISSIPPI	68.40

Computed from NEA Research, unpublished data.

C-21. PERCENT INCREASE IN INSTRUCTIONAL STAFF SALARIES, 1972-73 TO 1982-83

1. UTAH	153.88
2. WYOMING	144.68
3. HAWAII	139.34
4. KENTUCKY	137.70
5. OKLAHOMA	133.57
6. NEVADA	130.23
7. NORTH DAKOTA	128.80
8. NEW MEXICO	128.40
9. ALASKA	127.40
10. IDAHO	126.22
11. SOUTH CAROLINA	123.40
12. ALABAMA	123.31
13. TEXAS	123.02
14. MONTANA	118.69
15. COLORADO	118.62
16. WASHINGTON	118.35
17. KANSAS	117.14
18. LOUISIANA	116.50
19. OREGON	115.68
20. RHODE ISLAND	115.25
21. WEST VIRGINIA	114.11
22. MINNESOTA	113.39
23. CALIFORNIA	111.34
24. DIST. OF COL.	111.30
25. ARIZONA	110.30
26. TENNESSEE	109.68
27. MISSISSIPPI	108.00
28. WISCONSIN	106.77
29. OHIO	106.27
30. MASSACHUSETTS	105.36
31. ARKANSAS	105.21
UNITED STATES	103.81
32. NEBRASKA	103.61
33. MARYLAND	101.69
34. FLORIDA	101.59
35. PENNSYLVANIA	101.14
36. SOUTH DAKOTA	100.89
37. ILLINOIS	100.49
38. GEORGIA	100.46
39. INDIANA	100.20
40. NEW YORK	99.13
41. VIRGINIA	97.61
42. NORTH CAROLINA	95.88
43. MISSOURI	93.39
44. CONNECTICUT	94.37
45. NEW JERSEY	92.65
46. DELAWARE	92.19
47. IOWA	92.11
48. MICHIGAN	91.48
49. MAINE	74.68
50. NEW HAMPSHIRE	69.63
51. VERMONT	39.82

Computed from NEA Research, unpublished data.

C-25. AVERAGE SALARIES PAID TO FACULTY AT PUBLIC 2-YEAR COLLEGES, 1981-82*

1. ALASKA	$39,521
2. CALIFORNIA	30,817
3. MICHIGAN	26,330
4. ARIZONA	25,994
5. NEW YORK	25,776
6. MARYLAND	24,536
7. ILLINOIS	24,310
UNITED STATES	24,238
8. WASHINGTON	24,157
9. NEW JERSEY	23,743
10. WYOMING	23,738
11. MINNESOTA	23,708
12. WISCONSIN	23,648
13. HAWAII	23,477
14. DELAWARE	22,615
15. CONNECTICUT	22,592
16. MISSOURI	22,384
17. OREGON	22,345
18. TEXAS	22,222
19. RHODE ISLAND	22,139
20. NORTH DAKOTA	21,990
21. PENNSYLVANIA	21,949
22. MASSACHUSETTS	21,684
23. NEVADA	21,649
24. OKLAHOMA	21,430
25. OHIO	21,369
26. MONTANA	20,774
27. GEORGIA	20,691
28. UTAH	20,590
29. LOUISIANA	20,314
30. NEW MEXICO	20,139
31. VERMONT	20,041
32. IDAHO	19,965
33. COLORADO	19,932
34. VIRGINIA	19,839
35. KANSAS	19,598
36. ALABAMA	19,493
37. FLORIDA	19,272
38. IOWA	18,948
39. NEBRASKA	18,395
40. NEW HAMPSHIRE	18,357
41. KENTUCKY	18,344
42. WEST VIRGINIA	18,138
43. MAINE	17,911
44. MISSISSIPPI	17,907
45. TENNESSEE	17,699
46. SOUTH CAROLINA	17,527
47. ARKANSAS	16,987
48. INDIANA	16,528
49. SOUTH DAKOTA	15,827
50. NORTH CAROLINA	15,518
DIST. OF COL.	NA

NEA Research, *National and State Statistics of Faculty Salaries Paid in Higher Education, 1981-82.* Prepublication data.

*For Faculty employed on a 9-month contract.

C-22. PERCENT INCREASE IN INSTRUCTIONAL STAFF SALARIES, 1981-82 TO 1982-83

1. ALABAMA	14.60
2. OKLAHOMA	12.92
3. WYOMING	12.91
4. WISCONSIN	12.34
5. MINNESOTA	12.00
6. SOUTH CAROLINA	11.91
7. UTAH	11.09
8. FLORIDA	10.24
9. MONTANA	10.00
VIRGINIA	10.00
HAWAII	10.00
12. CONNECTICUT	9.87
13. TEXAS	9.76
14. KANSAS	9.50
15. COLORADO	9.49
16. NEW MEXICO	9.40
17. NEW JERSEY	8.70
18. MARYLAND	8.36
19. PENNSYLVANIA	7.92
20. INDIANA	7.70
21. OHIO	7.69
22. ILLINOIS	7.69
UNITED STATES	7.54
23. DIST. OF COL.	7.26
24. NEW YORK	7.11
25. IDAHO	7.00
TENNESSEE	7.00
RHODE ISLAND	7.00
28. MICHIGAN	6.95
29. MISSOURI	6.86
30. KENTUCKY	6.71
31. DELAWARE	6.60
32. GEORGIA	6.41
NEVADA	6.41
34. SOUTH DAKOTA	6.39
35. ARIZONA	5.77
36. IOWA	5.47
37. NORTH CAROLINA	5.24
38. CALIFORNIA	5.20
39. LOUISIANA	5.03
40. OREGON	4.99
41. NEBRASKA	4.62
42. VERMONT	4.61
43. MASSACHUSETTS	4.55
44. NEW HAMPSHIRE	4.11
45. NORTH DAKOTA	3.98
46. ALASKA	3.93
47. ARKANSAS	3.93
48. MAINE	3.84
49. WASHINGTON	2.00
50. WEST VIRGINIA	1.72
51. MISSISSIPPI	1.37

Computed from NEA Research, unpublished data.

C-23. AVERAGE SALARIES PAID TO FACULTY AT PUBLIC UNIVERSITIES, 1981-82*

1. ALASKA	$39,429
2. CALIFORNIA	34,297
3. NEW YORK	31,769
4. MASSACHUSETTS	31,093
5. WISCONSIN	30,810
6. CONNECTICUT	30,364
7. ARIZONA	30,240
8. MICHIGAN	29,934
9. NORTH CAROLINA	29,385
10. WYOMING	29,280
11. NEVADA	29,134
12. WASHINGTON	29,071
13. TEXAS	28,454
14. FLORIDA	28,253
15. COLORADO	28,213
16. PENNSYLVANIA	28,084
17. ILLINOIS	27,991
UNITED STATES	27,900
18. HAWAII	27,884
19. VIRGINIA	27,754
20. UTAH	27,513
21. MINNESOTA	27,497
22. DELAWARE	27,493
23. OHIO	27,414
24. SOUTH CAROLINA	27,304
25. RHODE ISLAND	27,345
26. NEBRASKA	27,233
27. GEORGIA	27,093
28. KENTUCKY	26,935
29. LOUISIANA	26,869
30. NEW MEXICO	26,618
31. IOWA	26,516
32. MISSOURI	26,479
33. INDIANA	26,303
34. OREGON	25,997
35. OKLAHOMA	25,605
36. KANSAS	25,630
37. MARYLAND	25,612
38. ARKANSAS	25,493
39. IDAHO	25,198
40. TENNESSEE	25,026
41. VERMONT	24,959
42. NORTH DAKOTA	24,799
43. WEST VIRGINIA	24,672
44. ALABAMA	24,619
45. NEW HAMPSHIRE	24,512
46. MONTANA	24,497
47. MISSISSIPPI	24,358
48. MAINE	23,098
49. SOUTH DAKOTA	21,472
DIST. OF COL.	NA
NEW JERSEY	NA

NEA Research, *National and State Statistics of Faculty Salaries Paid in Higher Education, 1981-82.* Prepublication data.

*For faculty employed on a 9-month contract.

C-24. AVERAGE SALARIES PAID TO FACULTY AT OTHER 4-YEAR PUBLIC COLLEGES, 1981-82*

1. ALASKA	$33,339
2. CALIFORNIA	31,134
3. NEW YORK	29,676
4. NEVADA	28,042
5. PENNSYLVANIA	27,282
6. DIST. OF COL.	27,009
7. ARIZONA	27,004
8. NEW JERSEY	26,372
9. WASHINGTON	26,314
10. MASSACHUSETTS	26,167
11. OHIO	25,798
UNITED STATES	25,690
12. CONNECTICUT	25,435
13. WISCONSIN	25,232
14. FLORIDA	24,986
15. MINNESOTA	24,640
16. MICHIGAN	24,618
17. ILLINOIS	24,579
18. MARYLAND	24,562
19. OKLAHOMA	24,478
20. NORTH CAROLINA	24,454
21. GEORGIA	24,382
22. TEXAS	24,245
23. OREGON	24,179
24. NEW MEXICO	24,138
25. COLORADO	23,986
RHODE ISLAND	23,986
27. NORTH DAKOTA	23,743
28. HAWAII	23,679
29. IOWA	23,587
30. VIRGINIA	23,441
31. DELAWARE	23,425
32. LOUISIANA	23,293
33. UTAH	23,280
34. SOUTH CAROLINA	22,884
35. MONTANA	22,780
36. INDIANA	22,771
37. KENTUCKY	22,645
38. MAINE	22,240
39. MISSOURI	22,163
40. IDAHO	22,096
41. TENNESSEE	21,984
42. NEW HAMPSHIRE	21,890
43. WEST VIRGINIA	21,816
44. MISSISSIPPI	21,803
45. KANSAS	21,729
46. NEBRASKA	21,592
47. ALABAMA	21,172
48. SOUTH DAKOTA	20,967
49. ARKANSAS	20,782
50. VERMONT	20,309
WYOMING	NA

NEA Research, *National and State Statistics of Faculty Salaries Paid in Higher Education, 1981-82.* Prepublication data.

*For faculty employed on a 9-month contract.

TABLE 6: BENEFIT SPECIFICATIONS OF ENROLLED EDUCATION GROUPS

Little Rock, AR
Arkansas Public School Employees
Number of Contracts = 24,000

ATTACHMENT II
From EDUCATION MARKET HEALTH CARE STUDY
Blue Cross-Blue Shield, 1980

Hospital Benefits	
Inpatient	
Number of days	365
Deductible	$100 - Maximum of 3 per family
Room Allowance	80% of semi-private room charge
Ancillary Allowance	In full
Outpatient	
Supplemental Accident Endorsement	$300
Medical/Surgical	
Copay	80% to $4,000 100% of remaining charges during year
Lifetime Maximum:	$250,000

Single dependent children are covered to age 19 or age 27 if a full time student in an accredited college or university.

TABLE 6 - (Continued)

SAN FRANCISCO, CA

	Los Angeles Unified School District Number of Contracts = 10,828	Tulare County Schools Number of Contracts = 2,596
Hospital Benefits		
Inpatient		
Number of days	365	365
Deductible	None	None
Room Allowance	Full, semi-private	Full, semi-private
Ancillary Allowance	In Full	In Full
Outpatient		
Emergency Accident	$200 per year maximum	$300 per year maximum
Medical/Surgical		
Deductible	None	None
Surgery	100% UCR	100% UCR
Major Medical		
Deductible	$100 per individual, 3 per family maximum	$50 per individual, maximum per family $150
Copay	80% (Carrier) 20% (Subscriber)	Carrier: 80% of first $2,000, 100% thereafter
Lifetime Dollar Maximum	$300,000	$1,300,000
Dental Plan		
Benefit Payments		
Amount	-	90% of applicable allowance
Maximum Payments	-	$1,000 per person each calendar year
Vision Care		
Physicians Services	-	80% of applicable fee schedule for physicians's services
Optometrists Services	-	80% of the reasonable charges for services of a licensed optometrist and for lenses and frames

TABLE 6 - (Continued)

	TOPEKA, KS	
	Unified School District #259 Number of Contracts = 2,681	Unified School District #305 Number of Contracts = 676
Hospital Benefits		
Inpatient		
Number of days	120	120
Deductible	$10 per admission	$10 per admission
Room allowance	Full, semi-private	Full, semi-private
Ancillary allowance	In full	In full
Outpatient		
Emergency accident	In full	In full
Minor surgery	In full	In full
Medical Surgery		
Deductible	None	None
Surgery	100% UCR	100% UCR
In-Hospital Medical	In Full	In Full
Major Medical		
Deductible	$300 per year	$100 per year
Copays	80% company, 20% member	80% company, 20% member
Lifetime Maximum	$250,000	$50,000

TABLE 6 - (Continued)

COLUMBUS, GA

	University of Georgia Number of Contracts = 8,626		Cooperative Purchasing Agency Number of Contracts = 5,000	
Hospital Benefits	**Plan A**	**Plan O**	**High Option**	**Low Option**
Inpatient				
Number of days	365	365	365	70
Deductible	$100 per admission	$100 per admission	None	None
Room Allowance	Full semi-private	$50 per day	Full semi-private	$40 per day
Ancillary allowance	In full	In full	In full	In full
Outpatient				
Emergency accident	In full (within 72 hours)	In full (within 72 hours)	In full (within 72 hours)	In full (within 72 hours)
Minor Surgery	In full	In full	In full	In full
Medical Emergency	In full (within 72 hours)	In full (within 72 hours)	In full (within 72 hours)	In full (within 72 hours)
Medical/Surgical				
Deductible	None	None	None	None
Surgery	100% UCR	100% per Schedule	100% UCR	$600 Maximum
Major Medical				
Deductible	$100 per person $250 per family	$100 per person $250 per family	$100 (maximum of 3 per family per benefit period)	$100 (maximum of 3 per family per benefit period)
Copay	80% company, 20% member	80% company, 20% member	80%-20% to $5,000, 100% thereafter	80%-20% to $5,000, 100% thereafter
Lifetime Dollar Maximum	$250,000	$250,000	$250,000	$250,000

TABLE 6 - (Continued)

CHICAGO, IL

	Chicago Board of Education N = 43,052 (Comprehensive)	Elgin School District #46 N = 2,144 (Comprehensive)
Basic Plan		
Deductible	None	None
Number of Days	365	365
Room Allowance	Semi-Private	Semi-Private
Hospital Services	In full, usual and customary	In full, usual and customary
Maximum Hosp. Benefits*	$40,000	$15,000
Medical-Surgical	In full per schedule	In full per schedule
Major Medical		
Deductible	$100.00	$100.00
Copays	80% carrier, 20% subscriber	80% carrier, 20% subscriber
Maximum*	$40,000	$15,000
Dental		
Amount	In full after payment of $50 deductible	-
Maximum	$1,000 per year	-

*Combined Total of $80,000 in lifetime benefits.

TABLE 6 - (Continued)

PORTLAND, OR

	School District #1 (Portland) (High Option) Number of Contracts = 3,255	Eugene School District #4 (High Option) Number of Contracts = 2,363
Hospital Benefits		
Inpatient		
Number of days	365	365
Deductible	None	None
Room Allowance	Full, Semi-private	Full, Semi-private
Ancillary allowance	In Full	In Full
Outpatient		
Emergency Accident	$500 per accident	$500 per accident
Medical-Surgical		
Deductible	None	None
Surgery	In full per schedule	In full per schedule
Major Medical		
Deductible	$50/year (single) $150/year (family)	$50/year (single) $150/year (family)
Copay	80% to $2,000; 100% over $2,000	80% to $2,500; 100% over $2,500
Lifetime Dollar Maximum	$250,000	$250,000

TABLE 6 - (Continued)

PORTLAND, OR

	School District #1 (Portland) (Comprehensive) Number of Contracts = 3,255	Eugene School District #4 (Comprehensive) Number of Contracts = 2,363
Basic Plan		
Deductible	None	None
Number of Days	365	365
Room Allowance	Semi-Private	Semi-Private
Hospital Services	Usual & Customary	Usual & Customary
Medical-Surgical	Usual & Customary	Usual & Customary
Major Medical Plan		
Deductible	Individual: $50.00 Family: $150.00	Individual: $50.00 Family: $150.00
Copays	80% to $2,500; 100% over $2,500 to $250,000	80% to $2,500; 100% over $2,500 to $250,000

Dental Plan	Part A (Basic)	Part B (Prosthetics)	Part A (Basic)	Part B (Prosthetics)
Benefit Payments				
Amount	1st year - 70% of UCR 2nd year - 80% " " 3rd year - 90% " " 4th year -100% " "	50% of UCR charges	1st year - 70% of UCR 2nd year - 80% " " 3rd Year - 90% " " 4th year -100% " "	50% of UCR charges
Maximum Payments*	$1,000 per year for subscriber & each eligible family member	$1,000 per year for subscriber & each eligible family member	$1,000 per year for subscriber and each eligible family member	$1,000 per year for subscriber and each eligible family member

*Maximum payment is for services under Part A and Part B.

TABLE 6 - (Continued)

RICHMOND, VA

	Educators and Associated Personnel Number of Contracts = 19,373	State of Virginia Colleges Number of Contracts = 26,755
Hospital Benefits		
Inpatient		
Number of Days	365	120
Deductible	None or $50.00 (optional)	None
Room Allowance	Full semi-private	Full semi-private
Ancillary Allowance	In full	In full
Outpatient		
Emergency accident	In full	In full
Minor Surgery	In full	In full
Medical/Surgical		
Deductible	None	None
Surgery	100% UCR	100% UCR
Major Medical		
Deductible	$100 (individual) $300 (maximum per family)	$100 (individual) $300 (maximum per family)
Copays	80% UCR to $5,000, 100% over $5,000	80% UCR to $5,000, 100% over $5,000
Lifetime dollar maximum	$250,000	$250,000

Chairman JACOBS. The next witness is Samuel Brightman, representing the National Council of Senior Citizens.

STATEMENT OF SAMUEL BRIGHTMAN, SPECIAL ASSISTANT TO THE EXECUTIVE DIRECTOR, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. BRIGHTMAN. Mr. Chairman, I am Samuel C. Brightman, special assistant to the executive director of the National Council of Senior Citizens. The National Council is a nonprofit, nonpartisan membership organization which represents over 4.5 million elderly people through over 4,200 clubs and State and area councils throughout the country.

As you can see, I am a senior citizen myself and the problem you are addressing is a little more urgent to me than it was some years back.

The council and I believe that we are facing a crisis that affects not just the elderly, although those of us on medicare are more and more at risk; it affects the whole good health of the Nation, financial security, and protection of all of our citizens.

We don't think it is possible and desirable to have a two-class health care where seniors get better care or the rich get better care. We are all in this problem together.

We believe that H.R. 3261 holds great promise for meeting what we consider a serious crisis, because it would save public and private health care dollars without shifting public savings to the private sector or undermining the financial security of users of medical care.

It recognizes that the private sector is affected not only by medical inflation but also by medical health budget cutbacks and, very important, it properly identifies medical providers as the health care system's decision makers, and gives them, rather than their patients, the responsibility for cost containment.

Just a few months ago, I was in the hospital and the amount of money that was spent on me while I was unconscious and not able to talk about it ran into several thousands of dollars. I get very disturbed when I hear them saying that senior citizens, by using their medicare with discretion, can save money on medical care. We are at the mercy of the medical profession and we have to give them the message that we want costs held down.

H.R. 3261 uses the prospective payment or budget concept, which I think is fair and effective, and it acknowledges the nationwide role that each State must play. We can't get this done without the States and we have to bring them in on a nationwide basis rather than at their convenience. Once again, it includes physician service and cost control.

Senior citizens are feeling more and more pressure. We are spending more and more of our limited incomes for items not covered by medicare. The budget cuts in medicare have put more of a burden on the senior citizen. We are well aware that hospital inflation threatens the solvency of the hospital insurance trust fund.

The U.S. health care spending increased in the last 2 years 15 and 12 percent—1981 and 1982 respectively. This occured during a

period when the Federal budget was being trimmed by billions of dollars. And what that has done is just shift costs or reduce access to care. We now pay more money out of pocket for the things not covered by medicare and more for the things covered by medicare.

The lower income persons among the elderly, who do not rely on medicare but on medicaid, find that their access to health service reduced. The savings proposals of asking the medicaid recipient to be responsible for the savings is a hardship on many vulnerable people.

We are aware of the pressures that Members of Congress have. I certainly am. I have been around this town since 1941. But I think that the Congress is going to have to stop playing with tinkering and stop gap and address this issue of medical cost containment square on. I think this bill has a chance of accomplishing that goal.

I thank you for the opportunity to be before you.

[The prepared statement follows:]

STATEMENT OF SAMUEL C. BRIGHTMAN, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, I am Samuel C. Brightman, Special Assistant to the Executive Director of the National Council of Senior Citizens. The National Council is a non-profit, non-partisan membership organization which represents over 4.5 million elderly people through over 4,200 clubs and state and area councils throughout the country.

NCSC was founded twenty-two years ago during the fight for Medicare legislation. Over the years we have worked toward improving the elderly population's health care protection. However, our concern about health care applies to people of all ages. We believe that until the health care needs of all citizens are met, the health care needs of the elderly will not be met.

A major obstacle to meeting the health care needs of the population is the rising cost of health care. As the cost increases, the adequacy of our public and private payment mechanisms is eroded, threatening citizens' health care protection, their financial security, and their health status. The nation is rapidly approaching this condition.

The National Council of Senior Citizens appreciates the opportunity to comment on the proposed "CHEC" legislation (H.R. 3261). We believe that CHEC holds promise for altering this condition. H.R. 3261 deserves Congressional support because:

It would save public and private health care dollars without shifting public "savings" to the private sector or sacrificing the financial and health security of individuals whether they are dependent on programs such as Medicare and Medicaid or private insurance.

It recognizes that the private sector—for example, workers and their employers, private health insurors, and individuals—are affected not only by medical inflation but also by Federal health budget cutbacks.

It properly identifies providers as the health care system's true decision-makers whose behavior affects costs.

It calls for prospective payment methods, thus placing providers, rather than patients, at financial risk in order to achieve effective, equitable, and long-term savings.

It acknowledges the significant role that the states must assume in any cost-control plan by mandating development of state plans and providing the incentives for states to establish their own all payer cost-control programs.

Mr. Chairman, a plan like CHEC is of vital interest to senior citizens. As you know, their health care needs are significantly greater than those of younger people. Yet Medicare fails to cover 56 percent of senior citizens' expenditures, more than one-half of which must come out-of-pocket. These pockets, incidentally, do not increase with medical inflation.

Rising health care costs actually have become a three-headed monster for older people: They pay proportionately more of their limited incomes for health care not covered by Medicare; budget cuts in the Medicare program have shifted costs to beneficiaries; and uncontrolled hospital inflation threatens the solvency of the Hospital Insurance Trust Fund.

Although the United States has needed a strong and effective health care cost-control plan for many years, none has been enacted, though several have been introduced. During the past few years, with the cost of health care approaching critically high levels, Congressional action has been limited primarily to Federal budget cuts. This piecemeal and ineffective approach is not cost-control.

In the last two years alone, U.S. health care spending increased by 15.1 percent (1981 spending over 1980) and 12.5 percent (1982 over 1981). These increases occurred during a period when the Federal health budget was being trimmed by billions of dollars.

These budget cuts have done little more than shift costs or reduce access to health care. Elderly people now pay higher levels of Medicare mandated cost-sharing as well as more money out-of-pocket for the inflated prices of prescription drugs and other non-covered health care necessities. Many low-income people who once qualified for Medicaid have been denied eligibility due to budget cuts that forced states to reduce their eligible population. Other people fortunate enough to remain on Medicaid rolls have found their benefits reduced because of Federal and state cutbacks.

How can our public policy-makers adopt these so-called "savings" proposals, which threaten the most vulnerable people, while tolerating inflation rates for medical services that are three and four times greater than CPI? How can the U.S. spend $322 billion on health care in one year without protecting every individual regardless of age, income, health or employment status?

Surely a sensible person would question the "cost-containment" approach advocated by the Administration and adopted by the Congress in recent years. The National Council of Senior Citizens not only questions this approach, but also calls for its immediate replacement.

The time has come for the Congress to stop tinkering around the edges of our nation's critical health care cost problem. The physical and financial health of senior citizens, of children, of workers—of all people—not to mention the financial solvency of the Medicare Hospital Insurance Trust Fund, can wait no longer for the change that is desperately needed.

Health program budget cuts will *not* solve the problem. Squeezing down on one payer or one group of providers just pushes the problem elsewhere, as the last two fiscal years clearly demonstrate. Protecting hospitals and physicians while imposing increasingly large financial burdens on their patients is not only grossly inequitable, it is also quite ineffective.

The National Council of Senior Citizens asks: Can our lawmakers continue to tell us that we must pay more for our health care, or receive less of that care, while they do little about it? Can they continue to argue where to cut the budget while health care inflation grows uncontrollably? We believe they cannot. We ask Congress to control costs fairly and effectively.

The point is simply this: reducing the Federal budget for health will not control health costs. There are better ways. One of these ways is CHEC. We ask this Subcommittee to look upon H.R. 3261 as a positive step toward controlling health's escalating costs.

The benefits of CHEC extend far beyond an immediate halt to rising health care costs. We believe that only through stopping the total health care system's rising costs will Congress then be able to:

Objectively examine Medicare's financial condition, enact measures to ensure trust fund solvency, and protect the program's beneficiaries;

Prevent personal income from being further eroded by continually increasing out-of-pocket health care costs, higher taxes, or health insurance permiums which parallel inflated medical costs; or

Reform our nation's health care system into one which protects all people through an approach that provides for access to comprehensive services, control of cost and quality, and delivery of services that is efficient.

Thank you for this opportunity to be heard. The staff of the National Council of Senior Citizens is ready to work with the Subcommittee staff toward enactment of H.R. 3261.

Chairman JACOBS. We thank you for your testimony, Mr. Brightman.

Mr. Cohen, representing the Save Our Security Coalition. You have 5 minutes.

STATEMENT OF HON. WILBUR J. COHEN, FORMER SECRETARY OF HEALTH, EDUCATION AND WELFARE, COCHAIR OF SAVE OUR SECURITY COALITION

Mr. COHEN. Mr. Shannon and Mr. Chairman, I always like to come back to this big room because I first came here in 1935. I would like to come back for 2 years more, and then I will have a record of having testified before the Ways and Means Committee for 50 years. I don't know that there is anybody else who can claim that record, but I am trying very hard to complete 50 years of work with the Ways and Means Committee.

I did spend over 5 years here when we enacted the medicare and medicaid legislation during 1961-65, so I have a very deep and abiding interest in the role of the Ways and Means Committee, and I am glad to be here today.

I would like to have my testimony put in the record, Mr. Chairman. It represents the support of over 140 organizations which support the Shannon bill, and that represents my official testimony in response to the organizations that I represent.

But I would like to say I come here in my other capacity too as a former Secretary of HEW, in which I believe I have a little bit of administrative experience in connection with the problems that are presented here. And I felt that since all my other colleagues were supporting the objectives of the bill which I do enthusiastically, I might give you another rundown from my experience which might be helpful to you in dealing with more of the specifics in the bill.

Let me say two things. While I enthusiastically support the bill, the problem of implementing what is in the bill is, next to building the pyramids, probably the most gigantic effort that the U.S. Government would engage in in relationship to the problems that are presented. I would not testify before you in favor of the bill if I were not completely aware of the gigantic administrative problems that are involved.

Now, the first thing I have to say is although I am a former Secretary of HEW, I no longer have faith in the administrative competence of the Social Security Administration or the Department of Health and Human Services to engage in this particular enterprise that I so enthusiastically support. You are putting on the Secretary of HEW and the staff there, and I have told Mr. Pickle this too in connection with the disability bill, you are putting responsibilities in connection with Mr. Shannon's other bill on the Department without giving them the staff competence to carry out what you have in mind.

Plus the fact that the politicization of the program in the last several years has resulted in the complete deterioration of the morale of the staff, and you would not be able to put the Shannon disability bill and this bill into effect along with the Jacobs amendment on diagnostic related groupings and get in the next year or two a competent administrative implementation of all of those things. At the present time there is an inadequate, incompetent administrative arrangement.

Now, that is why I so enthusiastically supported in the 1983 amendments taking social security out of the Department of Health and Human Services and restoring it back, as it was when President Roosevelt initially created it, as an independent board,

and I would say don't make this legislation effective until that is completed in the 1983 amendments which has not yet been implemented.

The implementation of the 1983 amendments to create a mechanism between Mr. Rostenkowski and Mr. Dole and selecting a third person has not yet been implemented even though you passed that legislation back in April. I would say this to you, it is not because of the Ways and Means Committee's fault. It is because of the body on the other side which has not yet picked their person, and I would urge Chairman Rostenkowski on your behalf to try to accelerate creating that.

Now, one other thing, Mr. Chairman, before I complete my statement——

Chairman JACOBS. You have 20 seconds to go, Mr. Cohen.

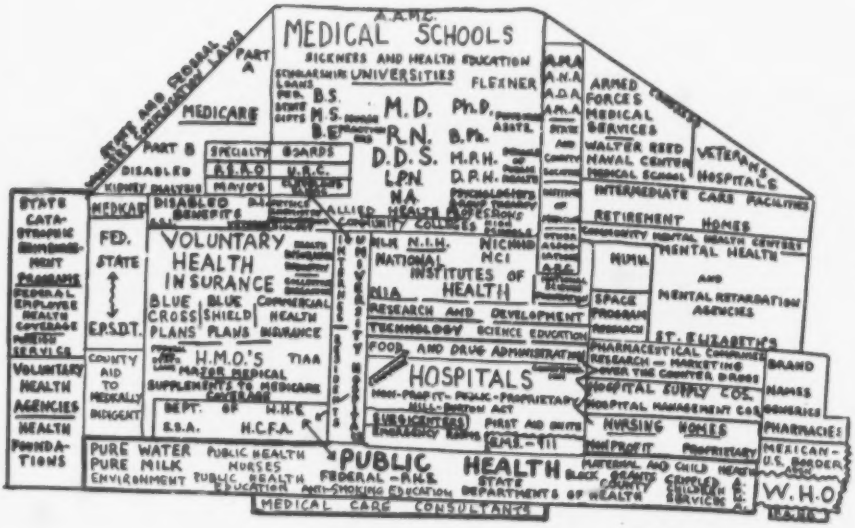
Mr. COHEN. Well, then, I will show you in the 20 seconds why you have got a difficult problem in implementing this legislation. This chart which I prepared is my conception of the health complex in the United States at the present time.

[The chart referred to follows:]

THE U.S. MEDICAL CARE COMPLEX

1983

10.5% G.N.P.



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Mr. COHEN. I present this to my students where I teach health policy at the LBJ School, and I tell them that anybody who tries to tackle the health industry at the present time with simplistic notions, whether they are cost containment, whether they are DRG's or anything else, is attacking building the pyramids.

You do not realize, unless you have really worked on this for some time, that the health complex or the health syndrome in the United States is impervious to what Congress and the administrative agencies are trying to achieve because it is so complex.

So while I could offer you, if I had time, a lot of specific suggestions on how to improve your bill, I want to say that while I again am enthusiastic in support of it, you have to do some administrative planning to make that feasible when you tackle cost containments.

I want to say one more point. This is a much better bill than what the Carter administration presented several years ago. I strongly believe that you can't have cost containment exclusively at the Federal level. It has to be at a State level with Federal supervision, but it is still a gigantic enterprise, and I think you ought to be very careful as to how you implement it.

[The prepared statement follows:]

STATEMENT OF HON. WILBUR J. COHEN, FORMER SECRETARY OF HEALTH, EDUCATION, AND WELFARE, CO-CHAIR OF SAVE OUR SECURITY COALITION

Mr. Chairman, I appreciate this opportunity to appear before your Subcommittee today, to testify in support of H.R. 3261, the Health Care Cost Control Act of 1983.

My name is Wilbur J. Cohen. I had the privilege of having served as Secretary of Health, Education and Welfare under President Johnson, and I was Under Secretary of HEW in 1965 at the time that Medicare and Medicaid were enacted into law. Just for the record—so that you will understand my long and unswerving commitment to, and involvement with, the related issues of Medicare and Medicaid—I should point out that I began working on these issues more than four decades ago—before 1940, to be exact.

I appear here today in my role as Co-Chair of the Save Our Security Coalition. I had hoped that the other Co-Chair of SOS—the Honorable Arthur S. Flemming, who was President Eisenhower's Secretary of HEW—could join me here today, but he had a prior commitment which took him away from Washington. I am authorized, however to tell you that his views are in complete conformity with those which I express today.

In addition, our organization also includes three former Commissioners of Social Security, two former Commissioners on Aging, and a former Counsellor to the President on Aging. All of us believe a strong and effective cost constraint program is necessary now and would have the support of millions of persons being adversely affected by mounting health and medical costs.

THE SOS COALITION

Before I begin, let me tell you something about Save Our Security.

SOS is a nationwide coalition of more than 140 organizations representing a cross-section of American life. I am attaching a list of our affiliates to give you the full flavor of the coalition. There are organizations representing the elderly, the blind and the disabled; trade unions representing those who are contributing to the Social Security system; social welfare groups, women's groups, veterans' groups, civil rights groups and religious organizations.

Together, these affiliated organizations have a membership of between 35 and 40 million adult Americans, almost equally divided between beneficiaries of, and contributors to, Social Security. This is a point which deserves special emphasis. The organizations within SOS speak for working men and women concerned about their own future protections under this program, and equally concerned about the benefits now being received by their retired parents and their grandparents. And we have organizations in the coalition which speak for older Americans who are con-

cerned, not only about their own economic security, but that of their children and grandchildren as well.

Within Save Our Security, in other words, we have successfully bridged the so-called "generation gap."

THE HEALTH CARE COST CONTROL ACT

On behalf of the coalition, I want to let the Subcommittee know of our full and unstinting support for the Health Care Cost Control Act of 1983, H.R. 3261, introduced by Representative Shannon. We believe that Congressman Shannon has played an important leadership role in this Congress on the basic aspects of Social Security—in the enactment of the 1983 amendments which strengthened the financing of the Old Age, Survivors' and Disability Insurance program; in the current fight to see that the safeguards of the Disability Insurance program are not eroded by overzealous, budget-conscious political ideologists downtown; and now in the important legislation before you, to insure that Medicare and Medicaid perform the roles which the Congress and the American people anticipated two decades ago when they became part of the law of the land and part of its basic social fabric.

We, in the coalition, are happy to have this opportunity to pay tribute to Mr. Shannon's leadership, and to endorse wholeheartedly the legislation which he and Representative Mikulski have introduced.

The 1965 passage of the Medicare and Medicaid legislation was a natural expansion of our total Social Security program. We were responding to an obvious need. For those over 65, Medicare acknowledged that our senior citizens required three times as much hospital care as the rest of the population, and that their health care needs were twice as high for younger age groups. For the needy poor, Medicaid was a recognition of the need for a Federal-State program to provide access to medical and hospital services which they could not otherwise afford.

In 1972, Medicare coverage was extended by the Congress to the disabled, the blind, and to individuals requiring kidney transplants and kidney dialysis—again, an acknowledgement by our society that, like the elderly and the needy poor, these persons incur medical care bills far higher than those of the average American family.

In the past two decades, in other words, America has been moving steadily forward to provide health benefits for those most vulnerable to extraordinary medical costs, and those least likely to obtain quality health care without these programs.

We must not stop this progress.

THE FACTS ABOUT MEDICAL CARE

Today, America faces inexorable inflationary pressures throughout the entire health care field.

In 1982, total national expenditures for personal health care were $322 billion. This represented 10.5 percent of Gross National Product—the highest share in history. It was up from 4.6 percent in 1950, and 8.3 percent in 1975. And this inflationary spiral continues unabated this year.

If these sharp increases in health care costs resulted solely from increased access to health care—if they resulted solely from a better quality of health care—then there would be no cause for concern. The benefits derived would be well worth the price.

But, sadly, adequate health care is still not available to everyone, even though it is a basic necessity of life. Medicare and Medicaid have improved financial access to some services for the elderly, the blind, the disabled and the poor. But in recent years, even those protections have eroded. And there are still many medically indigent persons who do not receive adequate preventive, diagnostic and treatment services.

Fact.—Laws passed in the last two years have reduced total Medicare outlays for the period from 1982 through 1986 by $21.6 billion below what they would otherwise have been.

Fact.—In addition to having funding for public health and medical care programs slashed, Medicaid beneficiaries have found that eligibility has been tightened and many millions have been removed from benefit entitlement.

Fact.—Economic barriers to medical care treatment have increased so much that the average Medicare beneficiary today pays approximately the same percentage of income for health care as was the case before this program was enacted into law.

Fact.—Health care resources are poorly distributed across the population and are skewed toward specialization, toward high-technology medicine, and toward "sick care" instead of health care.

Fact.—The use of health care is not always the most efficient and effective. People are hospitalized when they could be treated more effectively as out-patients, in some less costly setting, or at home.

Because of runaway health care costs, it is now being projected that the Health Insurance Trust Fund (Part A of Medicare) will face a financial imbalance as early as 1990. This is a problem in its own right; it is also a symptom of a much larger problem.

The current crisis in Medicare and Medicaid is more than a financing problem. It is a structural problem within the entire health care delivery system. Without major changes in the health care system as a whole, there may be no "band-aids" sufficient to maintain Medicare and Medicaid over the long run, no matter how successful we are in dealing with their financing problems in the short run.

In other words, any prescription for the financially ailing Medicare and Medicaid systems must also help remedy the existing national problems in the entire health care delivery system. Merely shifting the costs of Medicare and Medicaid from the Federal budget to States anbd localities, to program beneficiaries, to private insurors or to other individuals in need of health care, would only worsen the problem for everyone.

Our goal must be an efficient and effective health care delivery system which will provide access to decent health care to all people as a matter of right, in a fiscally and socially responsible manner.

OUR OPPOSITION TO THE REAGAN PROPOSALS

It is the contention of the Save Our Security coalition that the proposals being put forward by the Administration do not meet these tests of fiscal and social responsibility.

Instead of dealing with the basic causes of the medical care inflationary spiral, the Administration seeks, for the third year in a row, to reach into the pockets of beneficiaries. This would be a gross violation of the compact embodied in the Social Security program—a compact between the government and workers who have been paying into the Health Insurance Trust Fund all these years with the understanding that they would be entitled, if they become ill, to specified benefits.

According to all of the latest nationwide polls, most people under age 65 believe that Medicare will fulfill their health care needs when they retire. But this is not so. Until they reach retirement age, most (but not all) workers receive health care coverage through a group insurance plan where they work—usually the result of collective bargaining agreements. These plans vary widely, but virtually all of them include comprehensive medical care and many also provide major medical insurance. The result is that most workers are, to a very large extent, protected against the most devasting economic impact of ill health.

When they leave the workforce, and as they get older and more susceptible to illness, workers are going to find that Medicare actually falls far short of their expectations. It already requires a sizeable amount of patient cost-sharing, often higher than that provided for under the industrial policies workers are accustomed to; it provides virtually no protection against the most catastrophic illness; and, unfortunately, it does not cover services which the elderly most frequently need—preventive services, long-term care, prescription drugs, dental care and eyeglasses.

And now along comes this Administration which wants beneficiaries to pay an ever-increasing part of the costs of health care.

Under current law, a Medicare beneficiary going into the hospital pays a deductible—$304 at the present time, with this charge scheduled to go to $350 next year. Patients then pay nothing for the next two months—but if they're in the hospital longer than 60 days, they are required to pay an increasingly higher portion of their hospital bill.

The Reagan Administration wants to alter that arrangement drastically. It wants to force patients to pay $28 a day for the second through the fifteenth day in the hospital, and $17.50 a day from the sixteenth through the sixtieth day. At the end of that time, the Administration proposes cranking in a catastrophic insurance provision which would pick up the rest of the hospital cost.

The problem is that the average hospital stay for a Medicare beneficiary is ten and a half days, and for those over 80, it is approximately twelve days. So adding together the first-day cost and the additional cost-sharing proposed by the Administration, the average Medicare beneficiary would have to pay some $600 for one period of hospitalization. That would eat up nearly two months of benefits for the average widow on Social Security.

The Administration has two reasons which it gives for imposing these added costs.

First, it says, it would make people more "cost-conscious"—that it would serve as an "incentive" for them to keep their hospital stays short. But patients don't basically determine how long they are hospitalized. These decisions are made primarily by doctors and hospitals—by the people who often have a professional interest in keeping hospital beds full and the hospital out of bankruptcy.

How many times do you suppose that the doctor tells a patient, "I'm going to release you tomorrow," and the patient says, "No, let me stay another day or two"? Isn't it really the other way around? Isn't it the patient who usually keeps asking, "When are you going to let me out of this place?"

Imposition of charges during the first sixty days of hospitalization isn't going to reduce costs, it's simply going to add to the economic burden of the vast majority of Medicare beneficiaries.

The second justification the Administration gives for wanting to impose these added costs is that the income will help pay for catastrophic insurance coverage after sixty days. But there are only about 200,000 Medicare patients whose conditions—or whose doctors—keep them in the hospital longer than sixty days.

If the Members of this Subcommittee have any doubt as to the real reason behind this proposal to shift costs, I suggest that they look at the Administration's own statements, in which they proudly point out that this one provision would "save" billions of dollars in Medicare expenditures. Always remember: Every dollar "saved" in Medicare outlays means a dollar added to the financial burden of the elderly, the blind and the disabled.

Let me make our position clear:

We in SOS think catastrophic insurance is necessary in its own right. We simply do not believe that it should be added to the law at the expense of the vast majority of Medicare beneficiaries.

The Administration also has proposed increasing the premium on Part B of Medicare—it has proposed an annual increase in the patient's payments for doctors' services before Medicare benefits begin to take effect—it wants to require patients to pay a part of the cost of each doctor visit. Added together, these proposals would take $2 billion a year from the incomes of Medicare beneficiaries, many of whom are already below the poverty line and would throw millions more elderly, blind and disabled persons into poverty.

We in SOS likewise oppose the scheme to introduce a voucher system—offering beneficiaries the choice between staying in Medicare or receiving a voucher equal to the per capita value of Medicare. People who took the voucher could then shop around in the private marketplace for the health care insurance they hope would be right for them. if they chose a plan which cost less than Medicare, they could pocket the difference; if they chose a more expensive plan, they would have to pay the difference.

On the surface that might sound attractive. The problem is that private insurors could use financial gimmicks to lure individuals on fixed and low incomes to abandon Medicare in favor of lower-grade coverage. This could result in earlier death for some and unnecessary suffering for many who would be unable to afford health care over and above that which would be provided by the private insurance company.

The voucher scheme is bad medicine. It invites individuals to take a reckless gamble with their health and their economics. It is just one more effort to undermine the foundation on which a sound, broadly based social insurance program rests. Worse even than that, it would violate the compact which has existed between the American people and their government—a compact based on the idea that people build up entitlement to health care by their work and their contributions into the system.

We in SOS are also unalterably opposed to the idea being floated by the Advisory Council on Social Security to apply an income test to Medicare. Under this proposal, if you had an income of $25,000 a year for an individual or $32,000 for a couple, you have to pay all of your medical costs yourself. Workers would still have to make their mandatory contributions into the system, but they would not be guaranteed its protections unless they were in economic need. This would completely subvert the principle of a contributory, earned-right benefit—the foundation of all social insurance programs. Over the course of time, this would convert Medicare into a welfare-type system, which would run completely contrary to the spirit and intent of the law.

I have devoted considerable time, Mr. Chairman, to explaining our opposition to the proposals coming from those who opposed Medicare and Medicaid from the beginning; whose voices were raised against Social Security, itself, nearly half a century ago; and who have never ceased in their vocal opposition to this social insurance program. What concerns me most is that their voices are, if possible, even

more strident than before and, worst of all, they speak now from one of the great pulpits of power and influence in this country—the White House.

When this Administration recommends that we increase the costs of health care for those in need and, at the same time, reduce the protections to which people are entitled, it leaves us with no alternative but to concluded that its war on the poor, the elderly, the blind, the disabled and those most in need continues unabated.

This Administration may wish to break the promise which the government has made, and repeated over and over again—the promise to insulate these members of society against the economic ravages of illness. But we shall not stand idly by and let them succeed in this unworthy effort.

OUR SUPPORT FOR THE SHANNON BILL

The Health Care Cost Control Act of 1983, which you are now considering, stands in stark contrast to the Administration proposals. It is, first and foremost, compassionate. It recognizes the nature of the problem and offers a constructive, comprehensive approach to contain the costs of public and private health care programs while at the same time protecting the consumers of health care.

Congress took the first tentative step in this direction earlier this year when it incorporated into the Social Security Amendments of 1983 a provision for a prospective fee schedule—reimbursement by Diagnostic Related Groups (DRG's). This is a partial approach to hospital cost containment. But we have serious reservations about the effectiveness of the DRG plan because it is limited to Medicare and because its effects are uncertain. SOS has a committee of physicians, headed by Dr. Robert N. Butler, former Director of the National Institute on Aging of the National Institutes of Health, which will be monitoring the effectiveness of the DRG program. We will share with this Subcommittee, the Congress and the American people the results of Dr. Butler's study.

However, Congressman Shannon's bill goes a lot further than does the DRG plan enacted by the Congress. It is more equitable, more effective, and more far-reaching. Its purpose is to put a brake on runaway health care inflation across the board—which means that it would result in substantial savings to Federal, State and local governments, to private insurors and to the American consumer of health care.

It is not necessary for me to go into all of the details of H.R. 3261, but is might be useful to highlight what it would accomplish:

1. It would encourage States to develop their own creative approaches to health care cost containment by giving them incentives to achieve this goal and substantial flexibility in order to make this plan work.

2. It would create new incentives for efficiency in health care by moving the health care system in the direction of prospective payments for all payors—government, private insurance companies and individuals.

3. It would safeguard the quality of health care for the aged, the blind and the disabled by holding the line against further Medicare cuts which threaten to deny these people needed medical treatment.

4. It would put an end to massive cost shifting to employers and workers, who are being forced to pay increasingly higher insurance premiums in order to make up for reductions in receipts from Medicare and Medicaid.

This legislation is a realistic and achievable cost containment program which, in addition to yielding savings in Medicare and Medicaid, would also protect beneficiaries and patients.

But while logic and compassion are on the side of this legislation, I do not for a minute suggest that you will have an easy time enacting it into law. There is going to be strong opposition from those who oppose Medicare and Medicaid as a matter of principle; from the health care industry which has a vested interest in seeing Medicare and Medicaid continue as a blank check for the providers of health care to advocate unnecessary expansion and excessive utilization of services; and from those who value the concept of free enterprise so highly that they cannot, or will not, recognize society's obligations to provide people with health care services as a matter of right and human dignity, and at costs which are within reach of their family budgets.

So you are challenged with this legislation, but I have confidence that it can be, and will be, enacted into law and that, in the process, we will begin to put some sense back into the way health care services are provided and paid for—and do so in a way which keeps our system strong and our people healthy.

CONCLUSION

I would not pretend—nor, I think, does the author of this legislation pretend—that with enactment of H.R. 3261 will come the millenium. We all know that there will remain in America some serious holes in the health safety net. There still will be tens of millions of Americans without any health care protection at all—and this must be remedied. There will still be many urgently needed benefits (like prescription drugs, hearing aids, dentures and eyeglasses) which will not be provided to the elderly—and, in time, these must be added to the program.

But this legislation is a significant beginning.

Most of us in SOS favor—as the only realistic basic solution to the nation's health care problems—the ultimate goal of enactment of a comprehensive national health insurance plan with universal coverage and benefits, cost and quality controls, annual budgets, and a reorganized health delivery system with effective consumer participation. And every poll shows that the overwhelming majority of the American people agree with us—they want national health insurance.

That is our long-range goal; but we must begin somewhere, and H.R. 3261 is an excellent starting point.

I am reminded of a story about the late Pope John the 23rd.

It is said that the Pope was strolling through the Vatican grounds one noon when he was approached by a gardener carrying two tiny seedlings in his hand.

"Holy Father," the gardener said, "these two seedlings have just arrived from America. They are from the famed Sequoia trees which, one day, will tower over the dome of St. Peter's Basilica."

"How wonderful," said the Pope. "I cannot wait to see them."

"But, your Holiness," the gardener said, "they will not reach their full maturity for a hundred years."

"In that case," Pope John said, "we haven't a moment to lose. We must plant them this afternoon."

I wish you good planting, Mr. Chairman—no matter how long it takes for a fully operative, compassionate, comprehensive health care program to reach its full maturity. I trust it will not take a hundred years.

AFFILIATED ORGANIZATIONS

A. Philip Randolph Institute
Action Alliance of Senior Citizens of Greater Philadelphia (PA)
Advocates for the Handicapped
Alton-Wood River (IL) Federation of Labor
American Association of Homes for the Aging
American Association of Retired Persons
American Association of University Professors
American Association of University Women
American Association on Mental Deficiency
American Coalition for Citizens with Disabilities
American Council of the Blind
American Ethical Union
American Federation of Labor/Congress of Industrial Organizations
American Federation of State, County and Municipal Employees
American Foundation for the Blind
American Jewish Committee
American Veterans Committee
Americans for Democratic Action
Armstrong, Clarion Counties (PA) Central Labor Union Council
Associated Actors and Artistes of America
Association for Retarded Citizens
Bakers, Confectionery and Tobacco Workers International Union
Cattaraugus-Allegheny Counties (NY) Central Labor Council
Center for Community Change
Center for Independent Living
Central Labor Union of Erie County (PA)
Central Maine Area Agency on Aging
Central Ohio Council of Senior Citizens
Cincinnati (OH) AFL-CIO Council
Communications Workers of America
Community Council of Greater New York
Concerned Seniors for Better Government
Congress of Senior Citizens of New York
Connecticut State AFL-CIO
Council of State Administrators of Vocational Rehabilitation
Democratic Socialist Organizing Committee
Disabilities Plus, Ink
Disabled American Veterans
Disabled in Action of Pennsylvania
Dunn County (WI) Central Labor Council
Economic Opportunity Commission
Edwardsville (IL) Central Trades and Labor Council
Federation of Senior Citizen Clubs and Organizations
Food Research and Action Center
Fund to Assure an Independent Retirement
Graham-Greenlee Union Club of Clifton (AZ)
Gray Panthers
Highland Valley (MA) Elder Service, Inc.
International Association of Bridge, Structural and Iron Workers
International Association of Machinists and Aerospace Workers
International Chemical Workers Union
International Ladies' Garment Workers Union
International Union of Operating Engineers
Joseph P. Kennedy, Jr., Foundation
Leadership Conference of Women Religious
Legal Research and Services for the Elderly
Massachusetts Association of Home Care Corporations and Area Agencies on Aging
Massachusetts Organization of Disabled Workers
Mechanics Educational Society
Metal Trades Department, AFL-CIO
Metropolitan Baltimore Council of AFL-CIO Unions
Metropolitan N.Y. Coordinating Council on Jewish Poverty
Monmouth County (NJ) Office of the Handicapped
Montana State AFL-CIO
Muskegon (MI) Labor Council
National Association for Human Development
National Association for the Advancement of Colored People
National Association of Private Residential Facilities for the Mentally Retarded
National Association of Retired Federal Employees
National Association of State Universities and Land Grant Colleges
National Black Catholic Lay Caucus
National Board of the YWCA
National Caucus and Center on Black Aged
National Center for Urban Ethnic Affairs
National Coalition for Older Women's Issues
National Conference of Catholic Charities
National Consumers League
National Council of Catholic Women
National Council of Churches
National Council of Jewish Women
National Council of La Raza
National Council of Negro Women
National Council of Senior Citizens
National Council on the Aging
National Education Association
National Farmers Union
National Indian Council on Aging
National Multiple Sclerosis Society
National Organization of Social Security Claimants Representatives
National Senior Citizens Law Center
National Society for Autistic Children
National Urban Coalition
National Urban League
National Women's Political Caucus
New Hampshire Association for the Elderly
New Horizons
Ohio Coalition of Senior Citizen Organizations
Ohio Rehabilitation Services Commission
Older Women's League
Operation Overcome of Lackawanna County (PA)
Operation Overcome of the Anthracite Region (PA)
Operation Overcome of the Lehigh Valley (PA)
Oswego County (NY) Labor Council
Ozaukee County (WI) Trades and Labor Council
Paralyzed Veterans of America
Pennsylvania Alliance of the Physically Handicapped
People United for Self Help
Power, Inc.
Retired Teachers Chapter, United Federation of Teachers
Retirees Union Club of Sierra Vista (AZ)
San Joaquin and Calaveras Counties (CA) Central Labor Council
San Mateo County (CA) Central Labor Council
Save Our Childrens' Security
Secure Our Children
Senior Citizens Task Force/United Planning Organization
Seniors for Adequate Social Security
Southeastern Oregon Central Labor Council
Student Services for the Handicapped
Texas Planning Council for Developmental Disabilities
Texas State AFL-CIO
The Workmen's Circle
UAW Retired and Older Workers Department
Union Club of Cottonwood/Verde Valley (AZ)
Union Club of Sun City (AZ)
United Association of Journeymen & Apprentices of the Plumbing and Pipefitting Industry
United Automobile, Aerospace & Agricultural Implement Workers of America International Union
United Cerebral Palsy Associations
United Furniture Workers of America
United Presbyterian Church
United States Catholic Conference
United Steelworkers of America
University of the District of Columbia/Institute of Gerontology
Washington Armed Services Committee
Washington State Labor Council, AFL-CIO
Waukesha County (WI) Central Labor Council
West Virginia Developmental Disability Planning Council
Western Gerontological Society
Westside Community for Independent Living
Wisconsin Council on Developmental Disabilities
Women's Equity Action League

Chairman JACOBS. Thank you, Mr. Cohen. The problem a few years ago was that we didn't have Mr. Shannon.

Mr. Shannon.

Mr. SHANNON. Thank you, Mr. Chairman.

Mr. Cohen and other members of the panel, let me thank you all for your testimony which is very helpful. Let me ask you specifically, Mr. Cohen, what preliminary steps, other than establishing an independent Social Security Administration, would you have us take prior to the enactment of this legislation?

Mr. COHEN. I have three specific suggestions, Mr. Shannon, which I could make.

First, I think implementing phase 1 in 90 days is too soon. I think that when you realize that we needed at least 11 months to implement medicare in 1965, and I think we really needed 18, I would say 90 days is too soon.

The reason I say that is that that is the big mistake this committee made in 1979 when it implemented the disability amendments. You enacted a lot of important changes, but you didn't ask the Appropriations Subcommittee to give the staff the money to carry it out. And what I am saying, again, to Mr. Pickle is don't enact his disability bill without being sure to supply the staff to do it.

Mr. SHANNON. I think that is a good point, Mr. Cohen, but it is also important to point out that this administration accelerated the disability reviews when it came in ahead of the schedule which the previous administration intended. While we might not have given them enough time, this administration said they needed even less time than that.

Mr. COHEN. Well, I spent 30 years in the Department. I think I have a good appreciation of what they can do and what they can't do, and I have come to the conclusion that what you are asking them to do in this, and I have gone through every part of the bill where it says by regulation. I know what it is, as a former secretary, to have to sign regulations and study them. I think you are giving them too big of a job in too short of a time. That is No. 1.

No. 2, I think that what you should do first is provide a series of grants to the States to get ready for the State function in the cost containment. You are asking in phase 2 to give the States permission within 120 days to implement the State part of the cost containment. I think that is very important.

But, sir, the States are not prepared for this. They are not prepared for this. There is only about 8 or 9 States up until now that have done this, and the other 40 States need a lot of other help. They are not going to do it unless you either give them a greater incentive on medicaid, which you do in the bill, or some other way to get the State started first. Look at it the other way. Get the States started, and then it could be implemented. That is No. 2.

No. 3, I would think you would have to be more precise about the five or six places in the bill where you say the Secretary shall do something by regulation. That has been the whole problem on disability and medicare during the last few years. As soon as you say it will be accomplished mysteriously "by regulation," there is still no God-given knowledge how to solve these complex problems within 90 days.

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I would take every one of those "by regulations" out and find another mechanism to either define what you have in mind or enact some other alternatives because I think you are just then pushing forward the conflict between the hospitals, the physicians, and States on various issues.

So, I think you need to do a little bit more work in those areas because I would like to see this thing succeed. I am very concerned that it succeed properly, but I would urge you to maybe have another hearing in which you are more precisely dealing with those administrative problems than the general philosophical concerns.

Mr. SHANNON. Well, I think those three issues are all very important ones, and I think you have made some excellent points on them. I just want to say that as the sponsor of the bill on this side, I certainly would be very willing to work with you in each of those areas. We want to make sure this can be administered. There is no question about it.

I agree that if we do it in too much haste, chances are we are going to run into some problems that we haven't yet anticipated. So, I think that is important.

I do want to say that I think we are in a difficult position on this question of the discretion of the Secretary of Health and Human Services. We don't want to deny the administration, whatever administration, flexibility in dealing with these programs. We don't want to be so specific in the way in which we legislate that there is no administrative flexibility to do things in a more efficient way.

At the same time, we don't want to give the administration, if it disagrees with some aspects of this legislation, an ability to thwart those through the regulatory process. So, it is a very narrow line we have to walk here. We can talk more specifically about that.

Mr. COHEN. I would like to say this, Mr. Shannon. I think since the biggest thing that has happened in the Department in the last 2 years has been the appointment of Martha McSteen as the acting Social Security Commissioner. I think she is teriffic. I now have a greater degree of confidence that Mrs. McSteen will do a good job, better than the last Commissioner on Social Security who I think is really responsible for the complete deterioration of the disability program.

So, I would say social security would be in a little bit better shape, and, I think, with the appointment of Mrs. Heckler, she is much more sensitive to the needs of the human aspects of this program.

So I feel a little bit better today than I did a few weeks ago.

Mr. SHANNON. Mr. Cohen, if I might say, I think it is time we had a full-time Social Security Commissioner rather than an acting one. We haven't had a Social Security Commissioner who has been in that job on a permanent full-time basis since the beginning of this year, and I think that is——

Mr. COHEN. That is exactly why I would like to go back to the old Social Security Board of three members with an executive director and I will tell you why, too. Because with a board, you will depoliticize the program, which I think is very important. I think there has been too much politicization of the program without being sensitive to the fact that there are 115 million people contributing to

this program every year and 36 million people drawing benefits, and you have got to keep their interests in mind.

The way to do that is to have a tripartite arrangement that is more sensitive to the needs of people.

Mr. SHANNON. If I could just ask one more brief question of the other panelists, anybody who would like to comment on it. We have some cost-containment provisions that are existent in other States today, some of which are very tough. I was wondering whether you have heard complaints in any of your members in those particular States about the deterioration of quality of health care as a result of those State systems.

Mr. Hacking.

Mr. HACKING. Congressman Shannon, I have not heard any complaints from AARP's membership with respect to the quality of care in those States.

Ms. TARR-WHELAN. We have had no complaints. I served on the New York State Health Advisory Council under Governor Carey and was involved in a lot of discussions at the time that legislation was passed in the State of New York, and we heard lots of stories similar to those that Ms. Mikulski testified to earlier. None of those proved true, and the satisfaction with quality continued to be good there as well.

Mr. BRIGHTMAN. We have not had complaints about that. We are having an increase in complaints about the cost of things that are not covered, the total cost there.

Mr. SHANNON. Thank you all very much.

Thank you, Mr. Chairman.

Chairman JACOBS. The committee expresses its appreciation for the concise testimony and the helpful contribution to the record. This panel is excused.

The next panel, the Health Insurance Association of America, American Medical Association, Blue Cross & Blue Shield Association, American Hospital Association. Would the spokespeople for those organizations please come forward.

The panel is a allotted 20 minutes, 5 minutes for each witness. Any witness can yield time to another, but the panel will complete its formal testimony in 20 minutes.

Mr. Dorsch is the first person recognized.

Mr. DORSCH. I will submit my full statement for the record.

Chairman JACOBS. All statements will be printed there.

STATEMENT OF JAMES A. DORSCH, WASHINGTON COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. DORSCH. I am James A. Dorsch, Washington counsel of the Health Insurance Association of America. We are pleased that you are raising the issue of rising health costs immediately after the passage of H.R. 1900, the Social Security Amendments of 1983.

The change-in-payment basis under medicare would probably not have been proposed were it not for the persistent, rapid increases in health-care costs in recent years. However, these increases and their effects on Government programs are just as applicable to the insurance coverage purchased by employers for their employees and by individuals for themselves and by the self-insured.

As a result, health insurance premiums are increasing annually at rates which range from 20 to 40 percent depending on the size and location of the business.

These increases are ultimately shared by the employers, employees, and consumers and adversely affect the health of American industry. The Federal Government's past role as a catalyst has helped encourage variety, and innovation, and State all-payer cost-containment systems.

We believe this is the prime role for the Federal Government and should be continued. We applaud and commend the Congress for its recognition of qualified State programs as an alternate method of medicare payment under the Social Security Amendments of 1983.

We particularly applaud and commend the members of this subcommittee on both sides of the aisle for the initiative and leadership they showed in developing those particular provisions. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

We urge the Congress to take the next step on prospective pricing to enact legislation extending a hospital-prospective-pricing system to all payers, not just medicare, to take effect 4 years after enactment in any State which has not enacted a qualified State program.

Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. Such a proposal need not, and in fact should not, require the States to set up hospital-ratesetting commissions. It need not and should not require any particular type of program, ratesetting, DRG or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

It would provide a stimulus to those who believe our problems are best solved at the State level, to get the job done so there will be no need for a Federal all-payer program.

Another incentive would be a modest medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital-cost-containment programs in place on July 1, 1981. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into medicaid and other public assistance programs by health-care inflation.

We also recognize that any overall solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore, we continue to support the appointment of a Presidential commission upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with constructive resolution of the conflicts which make this problem so intractable.

Clearly, these ideas coincide with some of the concepts expressed in H.R. 3161. To that extent, we agree with the sponsors of that bill and applaud the initiative they have taken.

We appreciate this opportunity to present our views, and we will certainly be glad to work with the committee and the sponsors of H.R. 3261 for constructive solutions to the difficult problems facing us all with the rising cost of health care.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA PRESENTED BY JAMES A. DORSCH

I am James A. Dorsch, Washington Counsel of the Health Insurance Association of America. I am accompanied by Karen Williams of the HIAA Washington staff. The HIAA is a trade association of approximately 325 companies which together write over 85 percent of the country's commercial health insurance. We appear today on their behalf.

We are pleased that you are raising the issue of rising health costs immediately after the passage of H.R. 1900, the Social Security Amendments of 1983.

The recently enacted law serves as a good starting point for discussion of the issues. It changes Medicare's hospital payment from the present retrospective determination of incurred costs to a system of prospectively determined prices. We agree that this change in incentives is highly desirable. In fact, prospective payment may be our last chance for a competitive solution to rising hospital costs. However, the new prospective pricing system applies only to Medicare. Any system that does not apply to all patients will not produce the desired changes in hospital behavior.

The change in payment basis under Medicare would probably not have been proposed were it not for persistent, rapid increases in health care costs in recent years. These increases and their effects on government programs are just as applicable to the insurance coverage purchased by employers for their employees, by individuals for themselves, and by the self-insured. As a result, health insurance premiums are increasing annually at rates which range from 20 percent to 40 percent depending on the size and location of the business. These increases are ultimately shared by the employers, employees and consumers and adversely affect the health of American industry.

A prospective pricing system which applies only to Medicare will admittedly hold down Medicare outlays, but it could permit hospitals to shift to other payers an additional $6 billion from recent federal cutbacks. If the change to a prospective system provides the right incentives to hospitals to voluntarily control health care expenses, and we agree that it does, such a change is equally needed by those who are not eligible for Medicare.

The existence of cost shifting has become well-documented since our industry publicly identified the problem a couple of years ago. Cost shifting totalled $5.8 billion in 1982 and will rise to $7.9 billion in 1983.

As a logical business practice, hospitals recoup reductions in Medicare and Medicaid reimbursement by inflating charges to private patients. Those who are insured face higher premiums. Those who are not—such as laid-off workers who have lost their insurance—are faced with a ruinous hidden tax exacted at a time when they are least able to pay—a tax on their already sky-rocketing hospital charges. Without government action on an all-payer system, all private patients remain vulnerable to an unprecedented and financially intolerable level of cost shifting.

In theory, prospective payment leads to cost containment because hospitals will work with physicians to voluntarily reduce length of stay and ancillary services. The incentive for such behavorial changes is profit; hospitals will finally be able to get more money for doing less. But hospitals say such changes take time and substantial effort. In practice, hospitals will find it far easier to cost shift than to cost contain.

We support federal legislation that effectively protects private patients from additional cost shifts. Such protection could take the form of a residual prospective payment system for all-payers. However, an all-payer system would not necessarily require that all-payers pay the same price for each admission, service or procedure. But discounts ought to be justified by savings to the hospital and be available to all patients. As a practical matter Medicare could receive some special guarantees against program cost increases. Congress has already written into the law such a provision for any state system recognized by Medicare. Under the Social Security Amendments of 1983, if the Secretary of HHS finds that, over any three year period, Medicare has paid more under the state system than it would have paid oth-

erwise, the Secretary may reduce subsequent Medicare payments to hospitals under the system by that amount.

I would like to shed some light on arguments against an all-payer system. The Administration says that we private insurers will piggyback on the Medicare DRG prices once we recognize that we are paying too much for hospital care. Mr. Chairman, we already know we are paying too much but we are unable to pay less under a combination of current federal policies that generate cost shifting while prohibiting joint negotiation by insurers. We are caught between the competitive forces in the insurance market and the failures in the non-competitive hospital industry. Current comprehensive benefit contracts with employers would prohibit us from limiting our payments to hospitals to the Medicare rate because hospitals would bill employees for the difference. Employers and employees have made a conscious decision to elect comprehensive medical benefits in 90 percent of our group business.

If, in the future, an individual insurance company only offered to sell plans which limit benefits to the Medicare DRG rates, employers would again exercise their option in the free market to buy comprehensive benefits from another insurance company. What if the federal government intervened in the competitive health insurance market and prohibited the selling of comprehensive medical benefits; would you then indirectly succeed in controlling hospital costs? No, hospitals would charge patients all that the market would bear above the indemnity amounts. Many hospitals would soon find their solvency threatened as bad debts mounted.

You may ask whether we negotiate with hospitals to accept less than their charges as full payment. Hospitals have agreed to such requests to voluntarily reduce their revenues only where an employer or insurer has sufficient volume to force acceptance. Some Blue Cross plans so dominate their local areas as to be successful in obtaining such volume discounts. For the vast majority of the country, however, neither the insurance company nor the employer has sufficient local volume to negotiate charges and thereby prevent cost shifting. To drive home the point, the Prudential, which is the single largest private health insurer in the country, has only 4 percent of the private health insurance market, and that is spread over 50 states. We are too dispersed to negotiate individually and we are prohibited by antitrust laws from negotiating jointly.

We believe the Congress should specifically allow health insurers to share data and engage in joint cost containment activities, such as negotiating with health providers both with regard to price and patterns of care, and other such activities.

Experience validates our frustrations over cost shifting. Experience has also shown that second-opinion surgery, ambulatory benefits and other coverage designed to reduce utilization are successful but alone have limited impact. Finally, experience with State prospective payment systems clearly demonstrates their effectiveness in containing aggregate health care costs.

This is a developing area and no one yet can claim to have all the answers to the questions of a single hospital payment reform system. In fact, two of the oldest and most effective systems, the Maryland and New Jersey programs, operate quite differently. HHS recently granted waivers to New York and Massachusetts, two of the nation's high cost states. In both of these states, all parties with a direct stake in hospital payment change—providers, employers, unions and insurers—actively participated in designing a solution. Both are implementing approaches different from those in Maryland and New Jersey. We believe all of these different approaches will lower costs and produce useful comparisons.

Maine and West Virginia have also recently enacted all-payer programs which we hope will meet the new criteria for Medicare recognition.

The federal government's past role as a catalyst has helped encourage variety and innovation. We believe this is the prime role for the federal government, and should be continued. We applaud and commend the Congress for its recognition of qualified state programs as an alternative method of Medicare payment under the Social Security Amendments of 1983. We particularly applaud and commend the members of this subcommittee, on both sides of the aisle, for the initiative and leadership they showed in developing those particular provisions. We urge you now to adopt positive incentives to States to develop their own qualified programs for all patients.

One such incentive would be a Medicaid reward for those States which enact qualified programs similar to the reward in present law for States which had hospital cost containment programs in place on July 1, 1981. A modest Medicaid reward would be most appropriate for those States which are moving ahead to help solve a national problem-health cost inflation. It would be a fitting way to attack a national problem at the State level without a new Federal bureaucracy. It would be a fitting reward to those States which, by holding down rising health costs, are taking action to hold down the number of citizens forced into Medicaid and other public assist-

ance programs by health care inflation. Such a proposal need not, in fact, should not, require the States to set-up hospital rate-setting commissions. It need not, and should not, require any particular type of program, rate-setting, DRG, or otherwise, as long as the State program meets the criteria set forth in the Social Security Amendments of 1983.

We further urge the Congress to take the next step on prospective pricing—to enact legislation extending a hospital prospective pricing system to all payers, not just Medicare, to take effect four years after enactment in any State which has not enacted a qualified State program. Such legislation would give every State time to enact legislation suitable to its own particular needs and yet guarantee that all our citizens get the protection they deserve. It would also provide a stimulus to those who believe our problems are best solved at the State level to move ahead and get the job done so there will be no need for a Federal all-payer program.

We also recognize that any over-all solution to the problem of rising health costs requires a reconciliation of the vital interests of a number of important segments of our society. Therefore we continue to support the appointment of a Presidential Commission, upon which all of these interests, providers, insurers, employers, and unions, among others, can be represented and which can be charged with the constructive resolution of the conflicts which make this problem so intractable.

In summary, Mr. Chairman, the health insurance business shares your strong commitment to cost containment. It is a strong supporter of state prospective pricing systems which meet the criteria laid down in the Social Security Amendments of 1983.

We do not believe the Congress should mandate any particular kind of system, either rate review or DRG or any other, to the states in order to have a qualified program.

The HIAA does feel, however, that positive incentives should be enacted by the Congress to encourage the states to develop their own qualified programs. This could take the form of a Medicaid reward for enacting a program meeting the standards established in the Social Security Amendments of 1983.

We would also support Federal legislation which would give the state four years to act, after which the Federal prospective pricing system would apply in any State which had not enacted its own qualified program.

Clearly these ideas coincide with some of the concepts expressed in H.R. 3261. To that extent we agree with the sponsors of that bill and applaud the initiative they have taken.

We appreciate this opportunity to present our views. We will certainly be glad to work with the committee and with the sponsors of H.R. 3261 for constructive solutions to the difficult problems facing us all with the rising cost of health care.

Chairman JACOBS. Dr. Nelson.

STATEMENT OF ALAN R. NELSON, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY HARRY N. PETERSON, DIRECTOR, DIVISION OF LEGISLATIVE ACTIVITIES

Dr. NELSON. Mr. Chairman, my name is Alan R. Nelson, M.D. I am a physician in the practice of internal medicine in Salt Lake City. With me today is Harry N. Peterson who is on the staff of the AMA.

Mr. Chairman, H.R. 3261 represents a revised version of the national cost containment program proposed by the Carter administration in 1977, and rejected by the Congress.

In addition, it would institute price controls on physician charges. In our view, this bill should also be rejected.

Its ultimate effect would be to ration medical care. Like the former Carter administration program, H.R. 3261 is based on strict regulatory controls, arbitrary and rigid caps, massive bureaucratic administration, and harsh penalties.

Administration of the program would be highly complex and intrusive to the management of hospitals and the delivery of medical care in this country.

The system would be expensive to operate, would require extensive administrative procedures for modifications to the cap and limits and would provide no incentives or safeguards to assure quality care.

The bill would establish a system that would place all fees for medical services under the control of the Federal Government during the first phases of the program. The proposed system would lock in a fee structure that fails to recognize experience, skill, and other factors that make up legitimate fee differenciations.

Instead, fees would be arbitrarily tied to an index that fails to recognize excellence in service; would also oppose mandated assignment of medicare claims as provided in their bill.

In our view, a key to the high quality health care services available under medicare is the individual beneficiary's ability to seek his or her care through the free choice of a physician.

A change in the assignment policy, especially in the light of proposals to further hold down medicare part B reimbursement, could affect the access of medicare patients to the physician of their choice.

Proposed limits in hospital revenues would contravene the intent of Congress to provide incentives for hospitals to improve the management and delivery of their services as provided for in Public Law 98-21. Rather than encourage improved management of hospitals, they charge H.R. 3261 would, in fact, lock hospitals into their existing cost structures rewarding inefficient hospitals and penalizing those hospitals that have taken good faith efforts to reduce costs and improve their management capabilities.

We do not believe that the proposed cap on hospital revenues should be enacted. Congress has already set in motion major changes that will affect the way in which hospitals provide services and the cost of those services.

Private insurers are now also looking toward prospective pricing for hospital services. To place arbitrary revenue caps on top of a rapidly developing system could inappropriately affect changes now underway.

Mr. Chairman, in passing Public Law 98-21, Congress has provided authorization for States to establish statewide hospital reimbursement systems. Congress has also provided for a number of studies concerning expansion of the recently opposed prospective payment system.

Studies were also required concerning physician reimbursement and these studies are now underway. We believe that H.R. 3261 would establish unduly rigid requirements for States to develop programs and improperly mandate that all States establish statewide fee schedules for physicians' fees regardless of local needs and circumstances.

The proposal is unworkable and inequitable. This provision should not be enacted.

In conclusion, Mr. Chairman, the medical service and technology available to the American patient today are surely the envy of the world. The program proposed in H.R. 3261 is unduly restrictive and would establish a rigid system of regulation and controls that would prevent the free market and medical care from operating effectively.

Recent developments in the medical market place have led to increased competition in the medical market place and such competition is healthy. The program proposed under H.R. 3261, however, would replace the now-emerging competition with an additional massive layer of bureacracy as highly discriminatory and inequitable, placing controls on only one segment of the Nation's economy.

Such a system will not adequately address the needs of patients and should not be adopted.

Chairman JACOBS. Thank you for your testimony.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION PRESENTED BY ALAN R. NELSON, M.D.

Mr. Chairman and members of the subcommittee, my name is Alan R. Nelson, M.D. I am a physician in the practice of internal medicine in Salt Lake City, Utah. I am a member of the Board of Trustees of the American Medical Association. With me today is Harry N. Peterson, Director of the AMA's Division of Legislative Activities. The AMA is pleased to have this opportunity to comment on H.R. 3261, the "Health Care Cost Control Act of 1983."

This bill would establish caps on increases in revenues for all hospital inpatient services, as well as caps on charges for hospital out patient services and for all physician services. The proposal, while creating a federal mechanism to control health care costs directly, also provides, under federal control and direction, for alternate state operated, prospectively determined payment programs. The legislation goes beyond federal programs, such as Medicare and Medicaid, and would institute controls in the private sector as well. The bill would also mandate physician acceptance of Medicare assignment, and created a special commission to review technology and the appropriateness of medical procedures.

The bill creates a control program to be instituted under two phases. Under Phase I a federal program would cap increases in hospital inpatient revenue equal to an index based on labor costs and a nonwage marketbasket. Adjustments would be authorized for case-mix, and exceptions to the allowed increase would be permitted only in accordance with guidelines to be set by the HHS Secretary. Physician fees for services provided to hospital inpatients and in outpatient settings would be limited to increases related to office overhead expense and the CPI. Where hospitals or physicians had revenues in excess of the authorized increases, the excess portion would be deposited in an escrow account that would be forfeited to the government after two years. Hospitals and physicians with income below the allowed limit could petition the Secretary for the right to withdraw funds from their escrow accounts. Individuals and hospitals failing to make required escrow account deposits or making improper withdrawals would be subject to civil penalties equal to 150% of the appropriate deposit or inappropriate withdrawal. Where hospitals alter admissions practices to result in higher revenues under the proposal, they would be subject to fines and possible exclusion from the Medicare and Medicaid programs.

Phase II of the program would encourage states to develop their own rate setting system. If a state developed a program acceptable to the HHS Secretary, the state would receive a bonus in its Medicaid funding. States without an acceptable program would continue to be subject to the federal caps or to a federal imposed rate setting system.

COMMENTS

Mr. Chairman, this bill would create a nationwide program of revenue and price controls. In placing these controls on hospitals and physicians, it would highly discriminate against one segment of our economy. H.R. 3261 represents a revised version of the "hospital cost-containment program" proposed by the Carter Administration in 1977 and rejected by the Congress. In addition it would institute price controls on physician charges. In our view this bill should also be rejected.

Like the former Carter Administration program, H.R. 3261 is based on strict regulatory controls, arbitrary and rigid caps, massive bureaucratic administration, and harsh penalties. Administration of the program would be highly complex and intrusive into the management of hospitals and the delivery of medical care in this country. This system would be expensive to operate, would require extensive administra-

tive procedures for exemptions and modifications to the caps and limits, and would provide no incentives or safeguards to assure quality care.

The program, rather than encouraging competition using market forces, would establish national regulation of the costs and prices of medical services. The system would be based on penalties, rather than incentives. The proposal completely contravenes efforts by the Congress (through Medicare prospective pricing of hospital services) to encourage hospitals to improve their management and operations in order to provide services within a fixed price. It would also disrupt efforts in the medical community to develop new and more cost-effective methods of providing medical services to the American public. The proposal also ignores efforts in the private sector, through health care coalitions, business purchasers of health insurances, and the insurance industry itself to devise new and unique methods to encourage cost-consciousness in both the purchase and delivery of medical care services. The proposal also ignores any effort to place some restraints on the demand for medical services and, by restricting prices artificially, could in effect increase demand for medicare care.

The program establishes a cumbersome national regulatory system that would regulate hundreds of thousands of individuals and institutions that provide medical services. This proposal would reverse the Congressional direction towards deregulation of major industries and, in fact, would establish a regulatory system that would replace the free market in the health care sector.

While allowing for state programs, the bill in effect reiterates authority already granted to states in the Social Security Act Amendments of 1983 (PL 98-21) to establish statewide hospital prospective pricing systems and, therefore, Phase II of the proposal would be unnecessary.

PHYSICIAN CHARGES

The bill would establish a system that would place all fees for medical services under the control of the federal government during the first phase of the program. The bill would set a percentage increase limit for all medical service charges, including physicians' fees. This limit would apply to services provided to hospital inpatients, through hospital outpatient departments, and to private patients within the physician's office. Physicians and others charging higher than the cap amount would be subject to severe penalties for such "over charges."

Mr. Chairman, the American Medical Association opposes arbitrary caps on professional service fees in all sectors. We have indicated previously to this Committee our concern about arbitrary fee caps under the Medicare program and continue to believe that such caps are counter-productive. It is especially unfair to single out physicians for strict regulation of fees when the charges of most other professionals continue to increase, free of all controls. Moreover, the rest of the economy would remain free of all controls. This means that physicians would be faced with restraints on their charges, but there would be no such restraints on the rest of the economy.

While the proposal indicates that the federal limits would only be temporary and exist during the first phase of the program, in those states that fail to establish negotiated maximum fee schedules consistent with the strict federal requirements contained in the bill the federal controls would be permanent. In such a case, the system would lock in a fee structure that fails to recognize experience, skill, and other factors that make up legitimate fee differentials. For example, a physician just starting his or her practice could be severely disadvantaged, since under the program he or she could not raise charges to reflect improved skills and experience gained through years of practice. Instead, fees would be arbitrarily tied to an index that fails to recognize excellence in service. Such a fee system would appear to encourage the maintenance of the status quo and could even encourage mediocrity, since all individuals would receive relatively the same fees.

We believe that the proposal to control all charges for medical services is extremely ill-conceived, is highly discriminatory, and should not be pursued.

We also oppose mandated assignment of Medicare claims as provided in this bill. In our view, a key to the high quality health care services available under Medicare is the individual beneficiary's ability to seek his or her care through the free choice of a physician. Approximately 87 percent of physicians (including pediatricians and psychiatrists) treated Medicare patients in 1982, and approximately 80 percent of these physicians submitted some claims on an assigned basis. Under current law, beneficiaries are allowed a wide range of choice in determining who will be their attending physicians.

Currently physicians participating in the Medicare program have an option, on a claim-by-claim basis, to accept or not accept the Medicare-determined "reasonable" charge as payment in full (assignment). The ability to charge patients in addition to the "Medicare charge" recognizes the fact that the Medicare program does not reimburse physicians at the full usual, customary or reasonable charge. The direct billing option prevents the automatic application of the assignment procedure with its low Medicare reimbursement, and encourages many physicians to participate in the program. Congress considered these matters in providing an assignment option.

Because physicians have a choice as to whether or not they will accept assignment, Medicare beneficiaries are in turn able to select a physician from virtually the entire physician population. A change in the assignment policy, especially in light of proposals to further hold down Medicare Part B reimbursement, could affect the access of Medicare patients to the physician of their choice.

Physicians consider a number of factors in deciding whether or not to accept assignment on a particular claim: the nature and expense of the service provided, past payment experience with the Medicare carrier, the ability of the individual patient to pay for care on a par with non-Medicare beneficiaries, and the relationship between the physician and the patient. Statistics clearly point to the fact that most physicians are willing to accept assignment of claims.

The American Medical Association has spoken out in the past and will continue to speak out against changes to the Medicare program that will limit beneficiaries' access to care. We believe that the majority of physicians would continue to provide needed services to Medicare beneficiaries; however, we are concerned that the changes proposed could result in a growing number of physicians who will not participate in the Medicare program.

We must, however, point out that if this Committee has a goal a more widespread acceptance of assignment, this goal could best be accomplished by making the reimbursement level under Medicare more acceptable and in accord with usual and customary practices, and by expediting the billing and claims process. The fact that such changes would increase acceptance of Medicare assignment is borne out by the fact that of physicians not accepting assignment in 1982, 69 percent report that insufficient reimbursement was an important reason, and 36 percent say paperwork was an important reason.

HOSPITALS

Proposed limits on hospital revenues would contravene the intent of Congress to provide incentives for hospitals to improve the management and delivery of their services. The prospective pricing system, enacted as part of Public Law 98-21, establishes a system whereby hospitals which perform services for less than the fixed cost-per-discharge will be able to retain those resources, and whereby hospitals that have costs beyond the fixed cost will have to absorb the differential. Rather than encourage improved management of hospitals, H.R. 3261 would, in fact, lock hospitals into their existing cost structures, rewarding inefficient hospitals and penalizing those hospitals that have taken good faith efforts to reduce costs and improve their management capabilities.

Revenue caps are especially cumbersome in light of the dynamic nature of medical technology and the mobility of the population of the United States. Such a system would, by its very nature, require extensive exceptions procedures to allow for legitimate changes in patient-mix, new technology, and population shifts.

We do not believe that the proposed cap on hospital revenues should be enacted. We believe that Congress has already set in motion, through enactment of its prospective pricing system, major changes that will affect the way in which hospitals provide services and the cost of those services. It should also be noted that private insurors are now also looking towards prospective pricing for hospital services. To place arbitrary revenue caps on top of a rapidly developing system could inappropriately affect changes now under way. Finally, Congress has substantially modified the hospital reimbursement system under Medicare during the last two Congresses. The lead time for implementation of the prospective pricing system has been extremely short. As a matter of fact the system is still not operative and will become effective in just three days from today. Continued Congressional tinkering with the hospital reimbursement system could force hospitals to expend increased amounts of resources to cope with constant changes in the reimbursement systems, at the expense of patient care. The central focus of a hospital should be patient care—not how to deal with continuous changes in federal reimbursement policy and proposed controls.

STATE PROGRAMS

The bill contains, as a second phase, authority for states to adopt programs to control all medical costs within their boundaries. Such a system would include hospital costs and all outpatient costs. Physician services would be reimbursed based on statewide fee schedules developed by the state in a negotiated setting. States that indicate a willingness to develop such a program would receive a two percent bonus on their Medicaid reimbursement.

Mr. Chairman, in passing Public Law 98-21 Congress has provided authorization for states to establish statewide hospital reimbursement systems. Congress has also provided for a number of studies concerning expansion of the recently imposed prospective payment system. Studies were also required concerning physician reimbursement, and these studies are now underway. We believe that H.R. 3261 would establish unduly rigid requirements for states to develop programs and improperly mandates that all states establish statewide fee schedules for physicians' fees, regardless of local needs and circumstances. The proposal is unworkable and inequitable. This provision should not be enacted.

CONCLUSION

Mr. Chairman, the medical services and technology available to the American patient today are surely the envy of the world. While Congress does have a legitimate concern about federal resources devoted to medical care, we believe that the program proposed in H.R. 3261 is unduly restrictive and would establish a rigid system of regulation and controls that would prevent the free-market in medical care from operating effectively. Recent developments in the medical marketplace, including the development of new methods of health care delivery and increasing numbers of health care providers, have led to increased competition in the medical marketplace. Such competition is healthy and can properly allocate the needed resources to provide quality care for all our citizens. Congressional action has been important in the development of this competitive environment. The program proposed under H.R 3261, however, would replace the now emerging competitive marketplace with highly controlled central planning and control. The proposed program is highly discriminatory and inequitable, placing controls on one segment of the nation's economy. Such a system will not adequately address the needs of patients and should not be adopted.

Chairman JACOBS. The next witness is Lawrence Morris.

STATEMENT OF LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT FOR PROFESSIONAL AND PROVIDER AFFAIRS, BLUE CROSS & BLUE SHIELD ASSOCIATION

Mr. MORRIS. Thank you, Mr. Chairman. My name is Lawrence Morris, representing the 99 Blue Cross & Blue Shield plans operating in this country.

I appreciate the opportunity to testify on H.R. 3261, the Health Care Cost Control Act of 1983. While we strongly oppose the provisions of this bill, for reasons to be noted below, we do agree that the problems toward which the bill is directed—the still escalating costs of health care, and the potential for shifting some of those costs from the Government to and among other payors—are serious problems worthy of continuing congressional study.

We further believe that a major alternative to the approach offered by this bill is just now emerging, namely, the cost-containing dynamics of a price-competitive system. Our criticism of this bill is based on our view of the values of this alternative approach.

With your permission, I would like to submit my full statement for the record. For the moment, I will make only six points regarding the bill's ratesetting program.

First, the proposal underestimates and it would stifle the cost-containing innovations already underway in today's health-care-financing marketplace.

The impact would be largely to freeze in place a health system too frequently characterized by inefficiency and excess capacity.

Second, it would let too many participants in this industry avoid their responsibilities for health care cost containment and I include ourselves in that.

Third, the proposal pays too little regard to the diversity among the States and especially to the fact that many State's environments are not conducive to effective ratesetting programs.

Fourth, the proposal is based upon no persuasive evidence that such total regulation either improves the efficiency of health care institutions as such or would have any rapid impact on cost containment.

Fifth, the proposal would do nothing to prevent the kinds of cross-subsidization among payors that many perceive to be "cost-shifting." Instead, it would merely distribute among all payors the financial burden of the underinsured, the uninsured and any payors who fail to meet their obligations. Such institutionalized shifting of those unpaid obligations penalizes those payors, including Government, who cause fewer bad debts than other payors. The issues of financing care for the under-insured and the uninsured are important in their own right. We would urge that they not be swept under the rug of hospital rate regulation.

Sixth, the proposal would unnecessarily disrupt the evolution of the Government's role in health care financing. In the mid-1960's, Government, including the States, began a commitment to finance medical care for the elderly and the poor. The impact was dramatic, both in including the level of care provided those benificiaries and in raising total health care expenditures. Over time, the Government has tightened its definition of the reasonable costs for which it will pay. Most recently it has moved to becoming an even more prudent purchaser by determining and prospectively announcing what prices it will pay. The likely impact of that last step on provider behavior will be, in our opinion, as dramatic as were the initial effects of these Government programs. We understand and support the evolution in the Government's role and urge that this newest step be given an opportunity to take effect.

Mr. Chairman, I would like to assure you that we do appreciate the financial dilemma facing the medicare program. We understand that this dilemma has prompted this proposal, but in our view this proposal would not contribute to more effective cost containment.

With the just-enacted reform of the medicare program, we are entering an era in which the forces of price competition have just begun to work throughout the industry. We urge this committee to give those forces the time to operate.

We thank you for this opportunity.

Chairman JACOBS. Thank you for your testimony.

[The prepared statement follows:]

STATEMENT OF THE BLUE CROSS & BLUE SHIELD ASSOCIATION, PRESENTED BY LAWRENCE C. MORRIS, SENIOR VICE PRESIDENT

Mr. Chairman and members of the subcommittee, my name is Lawrence C. Morris, a Senior Vice President of the Blue Cross & Blue Shield Association representing the 99 Blue Cross and Blue Shield Plans operating in this country.

I appreciate the opportunity to testify on H.R. 3261, the Health Care Cost Control Act of 1983. While we strongly oppose the provisions of this bill, for reasons to be noted below, we do agree that the problems toward which the bill is directed—the still escalating costs of health care, and the potential for shifting some of those costs from the government to and among other payors—are serious problems worthy of continuing Congressional study. We further believe that a major alternative to the approach offered by this bill is just now emerging, namely the cost-containing dynamics of a price competitive system. Our criticism of this bill is based on our view of the values of this alternative approach.

This bill would first establish a short-term federal program of limiting all hospital revenues and some physician service payments. Second, it would authorize and encourage state systems of setting prospective hospital rates applicable to all payors. For many reasons, we would be opposed to the short-term federal program; we believe it would be an unwieldy, unnecessary and inappropriate federal effort to tightly regulate the largest part of a massive sector of the economy. For this testimony, however, I would like to focus on the long term proposal to encourage all states to establish all-payer rate setting programs. To our mind, this segment of the proposal raises all the major issues.

The essence of our opposition to H.R. 3261 rests on six points:

(1) H.R. 3261 does not appreciate, and would stifle, the cost containing innovations underway in today's health care financing marketplace.

(2) It would let too many participants in this industry "off-the-hook" regarding their responsibilities for health care cost containment—and I include ourselves.

(3) It pays to little regard to the diversity among the states.

(4) It is based on no persuasive evidence that such total regulation either improves the efficient of health care institutions or would have any rapid impact on cost containment.

(5) It would not eliminate cross subsidization among payors.

(6) It would disrupt the evolution of the government's role in health care financing.

As I elaborate briefly on each of those points, I would like to assure you that we do appreciate the financial dilemma facing the Medicare program. We understood that in part it is the dilemma that has proposed the proposal. Although we cannot support this proposal and do not believe that it would resolve the basic problem, we do want to offer our assistance to the Committee in coping with the larger problem of assuring the long-run solvency of Medicare. An important first step is to permit the prospective payment system about to be implemented to operate without undue complications.

EFFECT ON CURRENT MARKETPLACE INNOVATION

This proposal not only ignores but would inhibit the cost containing innovations that have begun rapidly to multiply in today's health care financing marketplace. An amazing diversity of creative responses to cost problems has sprung up in just the last 12 to 18 months. The concepts of prudent buying and selective contracting are finally taking hold, and the new Medicare prospective payment system is certain to foster their spread. These developments are already working substantial changes in the relationships of hospital to physician and payor to provider. With that kind of dynamic unfolding, now is not the time to freeze our health care institutions in their current position—as governmental regulation must inevitably do.

As just one example, I invite you to consider the impact of this proposal on California. The hospitals in California, which now have a state-wide average occupancy rate of less than 60 percent, are currently grappling with the new MediCal system, the onset of the new Medicare prospective payment system, and a flurry of preferred provider arrangements, including those sponsored by Blue Cross and Blue Shield Plans. Negotiations for "preferred rates" are underway all over the state. Preliminary results show a dramatic lowering of the prices to be charged by participating hospitals.

Some of the hospitals in California might look favorably on the kind of rate regulation that would emerge from H.R. 3261, for their financial worries would diminish. But this this is not the time to freeze the system and to stop what has just begun. Certainly we do not know what will emerge from the dramatic changes underway out there. We are convinced, however, that they are changes in the right direction and should be allowed to continue.

Another example is the new prospective payment program just adopted by BCBS of Kansas. In that case, the Plan is taking a DRG payment approach for its private subscribers similar to the Medicare Prospective Payment System. Under the Kansas

Plan's Competitive Allowance Program, beginning January 1, 1984, hospitals will be paid the lower of their charges per diagnosis or a maximum allowance payment per diagnosis. All the hospitals within an SMSA, or within a particular bed size category, will be subject to the same maximum allowance per DRG.

The Kansas Plan's new system will allow Plan subscribers the opportunity to compare the prices of services, and, more important, will provide strong incentive for effective management within a prospective price structure. It is certain to stimulate hospitals to be more cost efficient in their service planning and delivery.

COMPETITIVE RELIEF FOR PAYORS AND PROVIDERS

The proposal would destroy the powerful incentives that we, large employers, large unions, and increasingly the hospitals now face, to search for more price competitive, cost-effective means of providing health care. Under this proposal, the major responsibility and accountability for "cost containment" would be shifted to a regulatory agency of government. We believe that the marketplace forces now unfolding can and will do the job more creatively and effectively than any governmental program can, at least in most states.

MOST ENVIRONMENTS NOT CONDUCIVE TO RATE SETTING

The proposal underestimates the diversity among the states in terms of their respective traditions, health care resources, population trends, regulatory philosophies, and governmental capacities. In our experience, a few parts of the country (notably in the northeast) have and have had the resolve and environment needed to make extensive regulatory programs reasonably effective. Their experience suggests, as does the comprehensive character of this bill, that once a state starts down a regulatory road, the scope of regulation must inevitably grow broader and more powerful. Public and private sectors must get more intertwined and interdependent. I submit that most of the states in this country are not prepared to go that direction and will not have sufficient commitment to make it work.

LACK OF EVIDENCE SUPPORTING RATE

In our experience, and in the view of most experts on this subject, effective, long term cost containment requires a set of incentives that will promote more efficiency and cost effectiveness in the delivery of health care, and, importantly, lead to reduction in excess capacity. It is not clear that the rate setting programs already in operation do in fact create such incentives. Rate regulation does appear to create incentives to outmaneuver the system, to match accountant for accountant and lawyer for lawyer. In our view, a more productive set of incentives would flow from a price competitive marketplace. I would underscore that research on the current regulatory programs is very clear on one finding: such programs do not produce rapid results. We believe the marketplace dynamics now evolving will move more swiftly than the regulatory alternative.

THE INSTITUTIONALIZATION OF CROSS SUBSIDIZATIONS

The proposal would do nothing to prevent the kinds of cross subsidization among payors that many perceive to be "cost shifting". In other words, the proposal would do nothing to ensure that the amount a payor pays is related to the financial obligations its subscribers or beneficiaries incur in a hospital. Instead, as current state rate regulation programs have demonstrated, it would merely distribute among all payors the financial burden of the underinsured, the uninsured and any payors who fail to meet their obligations. Such institutionalized shifting of these unpaid obligations penalizes those payers (including government) who are responsible for causing fewer bad debts than other payers. Moreover, it can reduce the hospitals' incentive to pursue collection of bad debts, and can reduce the federal and state governments' incentives to maintain benefit, eligibility and payment levels in their programs. The issues of financing care for the underinsured and uninsured are important in their own right. We would urge that they not be swept under the rug of hospital rate regulation.

The debate about "cost shifting" has diverted attention from the more fundamental question of what costs should be paid. Those who complain of cost shifting are often too willing to pay whatever bill they get. As prudent purchasers of care we must constantly decide whether we are being asked to pay for services which are either unnecessary or unnecessarily expensive for our subscribers. In our view, this marketplace, like any other, should be disciplined by price sensitive negotiation between buyer and seller. The rapid development of "preferred provider arrange-

ments" all across the nation is demonstrating that such negotiation works, and not just for the very large payors. The answer to claims of cost shifting is more prudent purchasing, not more government regulation, and especially regulation that would penalize those who do the best job of prudent purchasing.

THE LATEST REFORM OF MEDICARE NEEDS TIME TO WORK

Finally, the proposal would constitute an unnecessary and disrupting intervention in the evolution of the government's role in health care financing. In the mid-1960's the government, including the states, began a commitment to finance medical care for the elderly and the poor. The impact was dramatic, both in improving the level of care provided to those beneficiaries and in raising total health care expenditures. Over time the government has tightened its definition of the "reasonable costs" of the care for which it will pay. Most recently it moved to becoming an even more prudent purchaser by determining and prospectively announcing what prices it will pay. The likely impact of that last step on provider behavior will be as dramatic as were the initial effects of these government programs. We understand and support that evolution and urge that this newest step be given an opportunity to take effect.

In summary, Mr. Chairman, we believe that H.R. 3261 is ill-advised, largely on two accounts.

In order to work, this proposal would require heavy regulation in all states, which, if successful, would largely freeze in place a health care system still characterized by excess capacity and serious inefficiencies. And secondly, this marketplace has recently become very dynamic in the pursuit of cost containing alternatives. Thanks in substantial part to the just enacted reform of the Medicare program, we are entering an era in which the forces of price competition will work throughout the industry. We urge this Committee to give the impact of these very new forces time to operate.

Thank you.

Chairman JACOBS. Mr. Owen.

STATEMENT OF JACK W. OWEN, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. OWEN. Thank you, Mr. Chairman. I am Jack Owen, executive vice president of the American Hospital Association. I appreciate the opportunity to appear before the committee today.

I think it is appropriate that this hearing is taking place today because this is a most historic time. In 2 days we are going to implement a revolutionary new prospective payment system which is the greatest change that has occurred since medicare was enacted in 1965, and we are anxiously waiting to see how this system is going to work.

We have worked very closely with this committee during the enactment and during the discussions of both TEFRA and the prospective payment system and we look forward to some kind of continued partnership as this is implemented and perfected because we think it is going to need some fine tuning.

One of the problems that we have as I listen to today's testimony, is that the reasons for health inflation never seem to come up; the expansion of access to health services by medicare and medicaid.

We have heard a number of witnesses say that the problem is strictly hospital costs. There are now 32,000 people over 100 years old in this country with a growing rate of those over 85, now at 17 percent.

We have an explosion and expansion of those over 65 and if there is no change in the trust fund and no change in the moneys going into that, there is no way possible that hospitals, physicians or Congress can continue to promise the over-65 the more than ade-

quate care that Senator Kennedy talks about and have the moneys to pay for it.

I think there are two approaches to limiting hospital costs and I might say, again, Mr. Chairman, that I am not opposed to cost containment. The American Hospital Association has never said that we are opposed to cost containment.

Our concern is what is the best way to provide cost containment for hospitals. We have looked at two of them: the incentive based and regulatory, the latter being this bill. Let me talk about the incentive based for a moment because this has the most promise, I think.

In 2 days prospective pricing starts. It is providing us with some incentives to increase productivity by looking at exactly what goes into each case. It should provide us with an excellent opportunity to reduce intensity of services within cases.

It gives us a chance to manage patient services in a way that we have not in the past. I was up in New Hampshire last week talking to some hospitals there and I heard a nurse from Beth Israel in New York say she was going to have now to reduce the nursing budget by some $750,000.

The question was, is that going to affect quality of care? Her answer was, no, that it was not, but it meant that there was going to have to be a different kind of nursing management within a large institution.

So I can see this is going to happen. We are going to have to reassess our investment in expensive technology. We have in the past taken technology that has been handed out by the makers of new and better equipment and we have utilized it without really assessing whether it was cost effective.

That is gone. We are going to have to assess. We are going to see new developments in referrals with hospital programs, et cetera.

So we think the incentive program does have possibilities, but you can't use the incentive system just with hospitals. There has to be an incentive for the patient, as well.

If the patient never pays any portion of his bill, there is no incentive to go to a hospital that is less expensive. What is going to encourage him to use less expensive care? We are going to have to look at that in the next few years.

On the regulatory side of—H.R. 3261—we are not in favor of this bill. We think it really fails to address the problem of health inflation over all.

There is no incentive in this system. As I heard the testimony—that there has not been a reduction in the quality of care with State rate reviews, I agree with that.

There has not been. But as you look at this kind of bill, in which there is a built-in kind of inflationary system because there will always be just an added increment to each one of these States as they go into this program, it appears to me that the incentive to do better will disappear and again the reliance on Government red-tape will cut short any kind of incentive for either patients or health care providers.

So we would not like to see this bill passed. I would like to commend the subcommittee and you, particularly, Mr. Jacobs, because

I know that you have been interested in this. You have held a number of hearings on this vital topic of health costs.

I think we need more hearings on it. I think we heard Mr. Cohen talk about some of the problems that he saw in implementation if this bill were passed.

I don't think we can go pell-mell as it is without a lot more careful study. I think there is a lot of need for discussion in the days ahead and I appreciate the opportunity to talk here this morning.

Chairman JACOBS. Thank you very much, Mr. Owen.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN HOSPITAL ASSOCIATION

SUMMARY

Enactment of the Medicare and Medicaid programs in the mid-1960's expanded access to health care services, with a spiralling of program costs: from $4.7 billion in 1967 to $46.6 billion in fiscal year 1982 for Medicare and from $1.5 billion in 1967 to $17.4 billion in fiscal year 1982 for Medicaid. Factors such as general inflation; utilization of services, particularly by the elderly; technological advances; and intense use of services have contributed to the significant increases in health costs.

Two solutions have been proposed to reduce such health inflation: incentive-based and regulatory. The incentive-based approach is reflected by prospective pricing, enacted this spring for implementation October 1, to bring cost incentives to the Medicare program. Other incentive approaches include a "cap" on deductibility of health insurance premiums, restructuring of Part A of Medicare, and experimental use of vouchers, all of which the AHA generally endorses. The regulatory approach is exemplified by H.R. 3261, the Health Care Cost Control Act of 1983, a proposal that the AHA views as failing to address the factors contributing to health inflation, lacking cost incentives, and relying too heavily upon government control.

In favoring incentives, the AHA is committed to working with the Congress in bringing cost consciousness to providers as well as consumers of health care.

INTRODUCTION

Mr. Chairman and members of the Committee, I am Jack W. Owen. executive vice president of the American Hospital Association and director of its Washington office. The AHA is the principal organization of this nation's hospitals, with approximately 6,300 member institutions and more than 35,000 personal members.

Thank you for giving me the opportunity to present the AHA's views on an issue of great concern to hospitals: rising health care costs. In my statement, I plan to address expansion of access to health services by federal programs; factors affecting health costs, such as inflation, utilization, technology, and intense use of resources; Medicare prospective pricing, an incentive-based approach to reducing increases in health costs; other incentive approaches; and H.R. 3261, the Health Care Cost Control Act of 1983, a regulatory approach to reducing costs.

FEDERAL ROLE IN EXPANDING ACCESS TO HEALTH SERVICES

The rate of increase in health costs is demonstrated by a rise in national health expenditures from 4.4 percent of the gross national product in 1950 to 9.8 percent in 1981. A significant portion of the increase in due to the creation of the federal Medicare and federal-state Medicaid programs in the mid-1960's, which expanded access to health services for the aged and poor. Increasing enrollments in these programs in the late 1960's and the 1970's were highlighted in 1973, when Medicare was broadened to include the disabled and those with end-stage renal disease.

Open access to health care services was the overriding philosophy, encouraged by cost-based payment of hospitals and charge-based fees for physicians, with limited consumer cost sharing. With increased availability of services offered by hospitals and with greater use of those services by beneficiaries, program costs spiralled, from $4.7 billion in 1967 to $46.6 billion in fiscal year 1982 for Medicare and from $1.5 billion in 1967 to $17.4 billion in fiscal year 1982 for Medicaid.

According to one estimate, total federal outlays for health are expected to increase about 12 percent a year, from $74 billion in fiscal year 1982 to $144 billion in fiscal year 1988. Of these outlays, the Medicare and Medicaid programs are projected to consume about 90 percent, with other health services, education and training,

research, and consumer and occupational health and safety accounting for the remainder.

With such growth, the philosophy of open access—without incentives for reducing the rate of increase in health costs—has begun to be challenged, leading to a search for balance between services and costs in the 1980's.

FACTORS AFFECTING HEALTH COSTS

Inflation

Inflation in the prices of resources used by hospitals has accounted for a substantial part of the overall increase in hospital costs. Such inflation occurs for various reasons: increases in wages and fringe benefits that hospitals, which are labor-intensive, pay to employees; higher prices for medical and housekeeping supplies, drugs and pharmaceuticals, food, fuel, and other items that hospitals purchase; and stepped up resources—new staff, supplies, and capital—that hospitals use to accommodate added admissions, particularly of the elderly, with greater intensity of services.

The effects of inflation, in terms of supply and other prices, were heightened in the recent past, but may be abating due to changes in overall economic performance. At the same time, hospital wage levels have risen more rapidly than wages in the general economy. For example, the proportion of highly skilled—and consequently, higher-salaried—professional staff has grown, due to the need for such personnel as medical records and utilization review staff and specialized nurses to work in intensive-care and other special units.

Behind the statistics—on wages paid, supplies purchased, and resources provided—are other factors that help explain the increases in total costs, such as utilization, technology, and intense use of resources.

Utilization

The expansion of third-party coverage, particularly through the Medicare and Medicaid programs, has—as indicated—substantially increased the demand for health care and has stimulated the choice of hospital care by discouraging the use of lower-cost alternatives to hospital services.

The rise in demand has been especially pronounced in the over-65 population. Approximately 26 million people 65 and older—95 percent of the elderly population—are enrolled in Medicare, contrasted with about 50 percent in that population group who had health benefits in 1967. By the year 2000, approximately 32 million persons are expected to be Medicare recipients.

Part of the increase in the use of hospitals by the elderly is the result of an aging of the population, the so-called "graying of America." Between 1970 and 1980, the population of persons 65 and older grew by 27.9 percent, while the total population increased by 11.4 percent. In 1980, persons 65 and older represented 11.3 percent of the population, compared to 9.8 percent in 1970 and 9.2 percent in 1960.

This 11.3 percent consumed nearly 33 percent of health care expenditures, a proportion that is expected to rise as the population ages. For those over 65, hospital expenditures are $869 per capita, compared with $370 per capita for those between 19 and 64.

Moreover, a shift in care patterns for the aged has been occurring, as organized health systems assume some responsibilities once accepted by families. The dramatic rise in nursing home care, for example—a doubling per 1,000 elderly in nursing homes from 1963 to 1977—may be as much due to changes in social patterns as to coverage under Medicaid of skilled nursing facility (SNF) and intermediate care facility (ICF) care, and to a lesser extent, under Medicare for SNF care.

Technology

With growing utilization has come accelerating technology, as a proliferation of intensive care units, development of artificial organs, creation of electronic implants, and innovation in new kinds of surgery have both saved lives and increased hospital costs. However, some procedures, such as drugs used in psychiatry and certain surgical procedures, have decreased costs, by reducing inpatient care.

While new technology has offered greater access to certain services, it has required extensive investment in equipment and specialized personnel. Community demand for full services may result in increased costs along with greater convenience. Moreover, technology may be utilized, even if its benefit is far from certain, because it is available. Overall, technological costs must be balanced with benefits to patients and communities, in terms of improvements in health status.

Intense use of services

Utilization and technological changes have meant more intensive use of services, not only of personnel—resulting in increased hospital employment and subsequent labor costs—but also of treatment protocols. Since the beginning of the Medicare program, there has been a substantial reduction in average length of stay, particularly among the elderly, with greater use of ancillary services for each inpatient day. As a result, overall intensity of hospital services has risen.

INCENTIVE-BASED APPROACH OFFERED BY MEDICARE PROSPECTIVE PRICING

Background

Two solutions have been proposed to the problem of rising health care costs: incentive-based and regulatory. The incentive approach is a fairly new concept in dealing with health costs. Its objective is to reestablish economic incentives that will lead providers and consumers to consider price and cost when making management decisions and using health services, respectively.

The prospective pricing system for Medicare inpatient services enacted as part of Public Law 98-21, Social Security Amendments of 1983, illustrates an incentive approach. Toward such an approach, the AHA last year proposed an interim prospective pricing system, based on average per-discharge payments. This system, while addressing the need for short-term savings in the Medicare program, was to have been an initial step in implementing a full prospective pricing plan for the long term.

Such a plan was necessary to bring structural reform to Medicare, because tinkering with the program's reimbursement system was no longer appropriate or workable. What was needed was a strategy of innovative pricing balancing financial rewards and risks, so that hospitals would be paid adequately for efficient and effective management and penalized for inefficient and ineffective performance.

Congress, in Public Law 97-248, the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, directed the Administration to draft its own prospective pricing proposal. Following presentation of the Administration draft to Congress in late December, the AHA further refined its own plan. With these as bases, the AHA worked with this Committee, the Senate Finance Committee, and the Administration in getting prospective pricing enacted. Although the AHA has some concerns about the prospective pricing system established by Public Law 98-21 and its implementation as proposed in interim final regulations September 1 by the Administration, the Association views initiation of prospective pricing as a positive step.

Provisions

Effective with each hospital's cost reporting period beginning on or after October 1 of this year, Medicare payment for inpatient hospital services will be on the basis of prospective prices, with separate prices established for each of 467 diagnosis-related groups (DRG's). These prices will replace the cost-per-case limits on Medicare payments created by TEFRA. The DRG system will be phased in over a four-year period, with separate urban and rural national DRG prices scheduled for the fourth year. During the preceding three years, payment will be a blend of hospital cost-per-case amounts, regional average prices for the DRG's to which patients are assigned, and national average prices for patient DRG's, with separate prices for urban and rural hospitals.

The system will apply to all hospitals except long-term, children's, psychiatric, and rehabilitation facilities and distinct-part psychiatric and rehabilitation units of general hospitals.

There will be special consideration of indirect and direct medical education costs, capital expenses, and atypical cases.

Cost incentives

Following are some of the strengths of the incentive-based approach of Medicare prospective pricing, in terms of how hospitals can use services more efficiently.

First, because Medicare revenues will be fixed, hospitals will have an incentive to increase productivity. Improvements in productivity entail review, and adjustment when necessary, of such aspects of hospital operations as management policies, staffing patterns, supplies, and work scheduling practices.

Second, under prospective pricing, hospitals will have an incentive to reduce the growing intensity of hospital care. Shorter lengths of stay and reduced utilization of ancillary services can, if combined with reductions in the resources used to produce services, result in substantially lower costs. The ability of hospitals to manage intensity is, of course, limited by several factors. Among the most important are patient

needs and professional standards of medical practice. However, management of intensity, particularly the intensity with which "high cost services" are used, offers considerable potential for reducing the rate of increase in total costs.

Third, hospitals will have an incentive to manage patient services. Specifically, hospitals will be looking seriously at the development of lower-cost alternatives to acute inpatient care. Conversion of beds from acute to skilled nursing care may produce substantial savings, as may the development of home health and other outpatient services. Combined with intensive discharge planning and patient education, the lower cost alternatives to acute inpatient treatment can reduce total lengths of stay and result in patients being in the lowest-cost setting consistent with their medical needs and preferences.

Fourth, hospitals will have an incentive to reassess investment in expensive technology. The acquisition of technology for specialized equipment, nursing units, and staff will to a significant degree be limited by the ability of the hospital to generate sufficient revenues to recover the generating expenses of the new services. Hospital payments will reflect the number of patients admitted that need and use the services for which costs were incurred. Hospitals, will therefore, limit acquisition of new technology to those areas in which the total volume of patients is sufficient to recover the fixed costs of the service, or in which the investment reduces other generating costs by more than the additional cost of the new service.

Finally, hospitals will have an incentive to develop regional referral arrangements to ensure access to needed specialty services. As the expensive technology offered by a hospital is limited to sufficient volume to recover fixed costs, hospitals lacking certain services will have to develop close relationships with facilities that provide such services. The result of such relationships will be continued access to services, with lower overall costs to the Medicare program.

Additional changes

Even with these incentives, the full benefits of prospective pricing will not be realized unless they are consistent with the incentives influencing other providers of health care and consumers of health services. As prospective pricing is implemented, changes needed to make the system more competitive will become apparent. For example, reforms are needed to ensure adequate payment rates for alternatives to acute, inpatient hospital treatment, such as skilled nursing or home health care for patients discharged from acute units. For another example, rewards are necessary for consumers who choose outpatient over inpatient services, when appropriate, and who select "lower priced" providers.

OTHER INCENTIVE-BASED APPROACHES

In addition to Medicare prospective pricing, other proposals are pending to introduce incentives into federal health spending. In the AHA's view, the most significant is a proposal to place limits on the deductibility of employer-paid health insurance premiums. Two other are restructuring of Medicare Part A to provide greater cost-sharing by and catastrophic illness protection for beneficiaries and experimental use of vouchers.

"Cap" on deductibility of health insurance premiums

The tax subsidy on employer-paid health insurance premiums is, in effect, the "third largest government health program" after Medicare and Medicaid in terms of cost to the federal government, according to one economist. Although not an entitlement, the subsidy also contributes to health inflation that plagues both Medicare and Medicaid by providing an incentive for employees to choose more health insurance than they would if they were using taxable income.

The Administration would like to generate $2.3 billion in fiscal year 1984 revenues by placing a cap on this subsidy: Limiting the deduction to $70 per month for individual coverage and $175 per month for family coverage.

In addition to raising tax revenues, such a cap would help remove the insulation that separates consumers from actual health costs. The theory is that exposure to costs would make consumers more cost conscious, thereby encouraging them to demand more cost-effective care and to use less costly services.

The AHA, agreeing that the tax subsidy of private insurance has contributed to inflation in health care costs, supports a cap on premiums. Reducing the rate of inflation means addressing not only Medicare and Medicaid outlays, but also private sector health spending, due to interrelationships between them.

Restructuring of medicare part A

In its budget proposals, the Administration also proposed that Medicare hospital benefits be restructured, so that beneficiaries would pay a deductible equal to one day of hospital care ($350 in 1984), 8 percent ($28) of the deductible for days 2 15, and 5 percent ($17.50) of the deductible for days 16 to 60. In order to provide protection to beneficiaries, the Administration recommended that unlimited catastrophic illness coverage be offered after the 60th day of hospitalization. For SNF care per illness, Medicare would cover the first 20 days, with copayments of 5 percent of the hospital deductible for days 21 through 100.

Currently, Medicare covers 90 days of inpatient hospital care per illness, with an additional 60 days of lifetime reserve. After an initial deductible of 304 (rising to $350 in 1984), there is no deductible for days 2 through 60. Daily copayments of $76 for days 61 through 90 and $152 for lifetime reserve days are required. For SNF care, the copayment rate for days 21 through 100 is 12.5 percent, higher than the Administration's proposed figure.

The AHA supports the Administration's intent in recommending restructuring of Part A as an important step toward cost consciousness by having beneficiaries share in the initial costs of treatment. Moreover, such restructuring would provide catastrophic illness protection, thereby removing the financial burden—and the fear of devastating costs—from the most severely ill beneficiaries.

However, the AHA believes that any restructuring should take into account the recently enacted prospective pricing legislation. First, the Administration's proposal is based on the per-diem cost of a hospital room. It should relate cost sharing to the DRG rate. Second, the Administration's proposal is based on all beneficiaries' paying the same amount of out-of-pocket expenses. It should relate cost sharing to the hospital providing the services, so that a beneficiary would have an incentive to choose a lower-priced facility. Third, the Administration's proposal is based on incentives for early discharge. The DRG-based prospective pricing system already includes such incentives.

Experimental use of vouchers

Yet another Administration proposal would inject incentives into the Medicare program by allowing beneficiaries to accept alternatives to Medicare coverage. Under the Administration plan, beneficiaries could choose to receive 95 percent of the per-person costs of the program, in the form of a voucher for purchase of a private health benefits plan.

This experimental use of vouchers, which would cost an additional $50 million in fiscal year 1984 but which could produce savings future years, is in line with the AHA's call for long-range structural reform of the Medicare program. As long as traditional insurers, as well as health maintenance and preferred provider organizations (PPO's), would be included as participants and as long as voucher plans would be required to provide benefit packages at least equal to Medicare's, the AHA endorses the proposal.

Further, the AHA favors the expansion of the voucher proposal to include hospitals as eligible health benefits organizations. As the centers of health care services for their communities, hospitals are uniquely qualified to plan and provide the type and range of health services needed and desired by their communities.

Guidelines for cost sharing

For consumers, changes in cost sharing can be used to promote more careful use of health care and selection of providers. When options for beneficiary cost sharing are being considered, the AHA believes that the following guidelines should be followed: First, consumer cost sharing should promote cost consciousness in the decision to choose inpatient hospital care or a less costly alternative, such as outpatient treatment. Second, it should be predictable, so that consumers are aware of out-of-pocket liability at the time decisions on provider and service are made. Third, it should be equitable, so that consumers are not denied access and seriously ill patients who require intensive care do not experience undue financial burdens. Fourth, it should be simple, as well as easy to understand and administer, so that consumers are not confused and administrative costs increased.

REGULATORY APPROACH PRESENTED BY THE HEALTH CARE COST CONTROL ACT

A second approach to the problem of rising health care costs is by regulation. The Carter Administration, in the 1970's, wanted to "control" hospital costs by gaining enactment of H.R.2626, its hospital cost containment bill. The Carter approach—imposition of mandatory caps on hospital inpatient revenues—was rejected by the

House in November 1979. Various arguments were used to defeat the proposal: its failure to address the causes of health inflation, absence of incentives for reducing the rate of increase in health costs, and reliance upon government and dependency upon red tape.

H.R. 3261's provisions

H.R. 3261, the Health Care Cost Control Act of 1983, introduced by Representative James Shannon, a member of this Committee, is companion legislation to S. 814, introduced by Senator Edward Kennedy. The measure is reminiscent of the Carter bill in that it would impose new limits on hospital inpatient revenues and require civil penalties—up to 150 percent of overcharges, lodged in escrow accounts—of hospitals exceeding the limits. It would freeze maximum hospital revenues at the base level, and adjust them upward only on the basis of market basket inflation. However, it would permit passing through of all wage increases, whether or not they were justified on the basis of prevailing wage rates. It would not provide for changes in patient case mix, but would reduce the cap on revenues if a hospital eliminated services—even underutilized services, unless approved by the state—in an effort to keep its costs within the revenue ceiling.

In a second phase, H.R. 3261 would "encourage" each state to establish its own prospective payment program (not necessarily DRG-based), according to strict criteria, and give the Secretary of Health and Human Services the authority to impose a program on any state without one after October 1, 1984. This approach—state rate review—has not been demonstrated to be effective, particularly when compared to the type of prospective pricing enacted by Public Law 98-21.

In addition to other problems caused by the regulatory approach—failure to address the causes of health inflation, absence of incentives, and reliance upon government control—state rate review shows unfair preferences for certain payers, which creates inequities; can result in rates so low that hospitals deplete their capital resources, jeopardizing their future financial stability and their ability to serve the poor; and attacks revenues rather than costs.

Failure to address health inflation

Like the Carter cap legislation, H.R. 3261 does not address the causes of health inflation. Under H.R. 3261, Medicare would continue to pay hospitals on the basis of retrospectively determined costs, subject to the system of cost-per-case limits created by TEFRA, unless a state adopted a system of rate review for all payers. Aside from undoing the progress that prospective payment legislation represents, H.R. 3261 does not take into account the utilization of health services, particularly by the elderly; role of technology (aside from establishing a short-term Advisory Commission on Health Care Technology and Procedures to examine technological advances); and intensity of resources that have contributed to increases in health costs.

Absence of incentives

H.R. 3261 does not recognize that consumer cost sharing has been shown in studies by the Rand Corporation and others to have a powerful effect on the demand for health services. Nor does it view consumer demand as a tool that can equitably be used to shape the demand for services, by emphasizing low-cost alternatives and deemphasizing those that result in high costs. Nor does it take into account the willingness of hospitals, other providers, and patients to contribute to solutions to the rising rate of health costs.

For example, throughout the country, innovative arrangements are being made by private sector groups—primarily PPO's—to meet the health care needs of certain segments of the population, while sharing risks and reducing rising costs. For instance, payer-based PPO's—organized by insurance companies, employers, and union trust funds—are negotiating contracts with providers and marketing newly created policies. Provider-based PPO's—formed by hospitals, physicians, or a combination of both and involving just one hospital or a network of hospitals—are marketing services to insurance companies or directly to employers. With such coalitions—innovative and flexible—springing up across the nation, the idea of the regulatory approach in H.R. 3261 seems both old-fashioned and rigid.

Reliance upon Government

H.R. 3261 puts the federal government at the fore, at a time when the trend is toward greater state and local control and more responsiveness to local needs. In its first phase, it would mandate federal control over hospital costs. In its second, it would force states to set up their own systems or accept the HHS Secretary's design. States establishing their own plans would have multiple requirements to meet, in-

cluding coming in under the federal cap and percentage controls on total inpatient hospital revenues.

As a result, this legislation, like the Carter measure, would create extensive red tape, at considerable administrative cost. Not only would it mix retrospective cost and pricing systems—requiring significant bureaucracy—but it would extend into every aspect of health care delivery. From hospital revenues to physician fees to laboratory costs, it would apply requirement after requirement that would have to be implemented and monitored.

Since the inception of Medicare and Medicaid, the hospital industry has been the focus of increased government regulation, a factor that the President acknowledged when he signed Executive Order 12291, to eliminate regulations that are burdensome or unnecessary. The AHA has actively participated in such elimination, whether it has involved excessive reporting and inspection, multiple centers of authority or accountability, or lack of incentives for hospitals to achieve effective delivery. One reason the AHA supported enactment of a DRG-based prospective payment program for Medicare was its potential for reducing the regulatory burden on hospitals in this nation. Enactment of H.R. 3261 would reverse the laudatory trend toward deregulation, which prospective payment—if given a chance—may continue.

CONCLUSION

Mr. Chairman, the AHA commends you and members of this Committee for examining the reasons for rising health costs and for seeking solutions to their deflation.

This Committee's hearing on health costs occurs at an historic time, two days before the implementation of the revolutionary prospective pricing system. Once this sytem is in place, subsequent steps can be identified, such as adjusting the prospective payment system to enhance incentives for cost-effective delivery and consumption of health services.

The dialogue has begun, and the AHA is committed to its continuation: to work with this Committee and other committees of the Congress to bring cost consciousness to both providers and consumers. Although this hearing is focused on an approach—H.R. 3261—with which the AHA disagrees, it offers an opportunity for exploration of other ways to reduce health inflation, through incentives that address its causes. The AHA looks forward to further exploration of the vital topic of health care costs.

Chairman JACOBS. Mr. Shannon.

Mr. SHANNON. Thank you, Mr. Chairman.

Dr. Nelson, in your testimony you talked about the percentage of physicians who take medicare on an assigned basis. What was that figure?

Dr. NELSON. I didn't give the figure in my testimony, Mr. Shannon, but about 80 percent of physicians accept medicare assignment for at least some patients, and last year about 52 percent of total medicare claims were on an assigned basis.

Mr. SHANNON. And let me just say that I would understand if you didn't have these figures directly today. Your representatives did give us the opportunity to ask whether we would have any questions that you should be prepared for, and I did not take advantage of that opportunity. But if you don't have these figures, I would hope that you would be able to provide us with them later.

I was just wondering, of those 80 percent, what percentage of the cases that they took did they take on an assigned basis?

Dr. NELSON. Well, it would vary from physician to physician. But of the total number of medicare claims filed, 52 percent were on an assigned basis. I, myself, accept medicare assignment for those patients who would have a hardship otherwise. For my patients who are relatively well off and can easily afford the copayment and deductible and the margin between the medicare assigned fee and my usual customary fee, I, of course, have the difference.

Mr. SHANNON. It is kind of hard to make that judgment sometimes?

Dr. NELSON. Difficult, but not impossible. And I feel better as a citizen having patients who can afford to pay the difference between the medicare fee, which is, in many instances, inadequate, and the usual and customary fee to have them do so, their costs aren't shifted to the other patients.

Mr. SHANNON. Of course, not all doctors approach it the way you do. I think we all run into constituents who have problems which result from the fact that not all the doctors do take assignment. It seems to me that this is a problem we are going to have to address.

Does the AMA oppose efforts by the States to institute cost-containment plans similar to the ones that have been instituted in Massachusetts, Maryland, and New Jersey? Is AMA opposed to those plans?

Dr. NELSON. To the degree that there is waste or inefficiency in the system, we are avidly trying to seek that out and correct it, and certainly we support trials of these kinds of concepts on an experimental basis, including DRG's and the kinds of experiments that are being conducted in Massachusetts.

But you have to understand also——

Mr. SHANNON. It is not really an experiment in Massachusetts. It is a system that has been put into place on a permanent basis.

Dr. NELSON. Yes. I understand. Although we don't know yet what the outcome will be.

But for Massachusetts, since it started as one of the highest cost States, in the first instance, a program that might be working very well there may not work very well in my own State of Utah, which is relatively lean in terms of health costs.

Mr. SHANNON. Well, that is one of the reasons why when the bill allows the States the flexibility to develop their own programs, I think the preferable approach would be for the States to do it on their own.

Dr. NELSON. Well, it permits them flexibility up to the degree that the Secretary permits. And, again, I would not want to see the care that I delivered to my patients rationed. The last patient that I lost in the hospital 2 weeks ago was a 76-year-old physician who was in the coronary unit receiving the kind of care that wasn't even feasible 10 years ago, and he and I agreed at each step of his care on what was reasonable and what he wanted. And after 2 weeks, he died. Our efforts weren't successful. But for him, the care that he and I agreed on was optimal achievable, the best that we could do, because he didn't want to die and I didn't want him to die. And at some point along that continuum, I would not have liked to have to tell him that: "Sorry, we can't go beyond this because the hospital revenues have to be considered."

Mr. SHANNON. Well, wouldn't increases in copayments have the same kind of effect?

Dr. NELSON. I think that to some degree copayments certainly induce a wiser purchase of care on the part of the recipient. But also——

Mr. SHANNON. It is a purchase if you have the money and you can make a judgment as to how you want to spend it? What if you don't have the money, or what if money becomes an issue?

Dr. NELSON. Well, I think, here again, the system currently provides in almost all instances that necessary care is given. My hospital will provide care for patients who are indigent, and I will do so, also.

Mr. SHANNON. Well, I wish that that were true for every sick person in the United States. Unfortunately, there is a lot of evidence that cost does become a big factor in determining whether some people get necessary medical care. I think that we all acknowledge that something has to be done.

I hope that you can provide me with some further information on how many doctors take total assignment of medicare. And I want to thank you for your testimony.

Dr. NELSON. Thank you, sir.

Chairman JACOBS. Mr. Rangel.

Mr. RANGEL. I regret that I was late. I didn't hear your testimony. But you may rest assured that I will read it. And I just assume, in concept, this is not the type of thing that you could support, but I will take a hard look at it.

Thank you very much for being with us.

Dr. NELSON. Thank you, sir.

Chairman JACOBS. Dr. Nelson, you testified that 52 percent of the medicare claims under part B were collected through assignment positions. Can you give us the percent of the medicare money paid out in part B that went through assignment?

Dr. NELSON. No; I am sorry, Mr. Chairman, I can't. But I will try and provide those data for you.

Chairman JACOBS. There could be a disparity and it could be wide. I don't know.

I would have to say, having read Mr. Owen's testimony and having read your testimony, Dr. Nelson, I see a rather strong thread of dissimilarity running through. Mr. Owen has testified that his association does not have fundamental disagreement with Government regulation.

I gather from the thrust of your testimony that your organization does. Would that be fair to say?

Dr. NELSON. Well, I don't feel that I can speak for my colleagues from the Hospital Association.

Chairman JACOBS. No, no; for your own.

Would you characterize that—that is what I divine from reading your testimony—that you have a fundamental disagreement with Government regulation generally?

Dr. NELSON. Mr. Chairman, we have a fundamental difficulty with the concept of rationing medical care, because technology will be rationed. Earlier there may be some margin of waste and inefficiency that can be removed through a cap on revenues, but once that is removed, and that is a one-time thing, then any cap will curtail future technology and must impact on the quality of care. And that is a fundamental problem that we will always have.

Chairman JACOBS. Well, what about my question? Is it generally your position that Government regulation is unacceptable in this field?

Dr. NELSON. Oh, I am sorry. I probably didn't completely understand.

Chairman JACOBS. It has always been rationed, since the dawn of creation, to those who could afford it for whatever reason.

Dr. NELSON. There are certain forms of regulation that we very clearly support. We supported the FDA. We support State licensure. We support our own self-regulatory activities. So, no, we aren't always opposed to regulation.

Chairman JACOBS. Would it be fair to say, though, that everybody is more or less willing to accept Federal money and more or less not willing to accept Federal regulation? I get that from testimony from the farmers when I read it occasionally, and I probably get it from my own testimony.

Isn't that pretty much human nature?

Dr. NELSON. I suppose you are asking me to agree with your premise.

Chairman JACOBS. I am asking you whether, if these folks who come to you can't afford anything beyond what the Government will pay, if they can't afford anything and you can only be paid whatever you are paid through assignment and through what the Government will pay, you would still take the money, wouldn't you?

Dr. NELSON. I, as an individual, if the patient can't afford to pay the difference on the assigned basis, of course I accept assignment.

Chairman JACOBS. We thank the panel for its contribution to the record. It has been a good one. We appreciate it.

The next panel consists of the American Federation of Labor and Congress of Industrial Organizations; American Federation of State, County & Municipal Employees; Service Employees International Union; International Union, United Automobile, Aerospace & Agricultural Implement Workers of America. Occasionally it is good to know what UAW stands for, I guess.

The AFL-CIO is first. You must be somebody. Would you identify yourself? You don't look exactly like Bob McGlotten.

STATEMENT OF KAREN IGNAGNI, ASSISTANT DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AFL-CIO ON BEHALF OF ROBERT McGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION

Ms. IGNAGNI. My name is Karen Ignagni, assistant director of the Department of Social Security at the AFL-CIO, and I am sitting in for Bob McGlotten who was called to the Senate side. I would like to summarize my remarks and submit my prepared statement for the record.

Organized labor has long been concerned about uncontrolled increases in health-care costs. As you know, we vigorously supported comprehensive cost containment when it was last under consideration by the Congress, and have given strong support to efforts to enact statewide cost-containment systems. Our affiliates and local unions have made major efforts to control rising costs through collective bargaining and participation in local health-care coalitions. I think you will be hearing more from my colleagues on that point.

As you may know, representatives of organized labor and the Health Security Action Council have been very involved in the development of H.R. 3261, which we view as a substitute for cruel

and arbitrary budget cuts and the only way to control the total rate of increase in health care costs.

Earlier this year, Congress took a significant step toward reforming the health-care-reimbursement system by requiring hospitals which participate in medicare to be paid on a prospective basis. Although we supported efforts to introduce the concept of prospective budgeting into the medicare system and discontinue the practice of paying providers whatever they spend, we do not think Congress went far enough.

Without strong utilization controls, restraints on unnecessary hospital construction and coverage of physicians within the prospective rate, the cost of medicare could continue to increase at double-digit rates. In addition, the prospective reimbursement system for medicare alone may give hospitals strong incentives to turn away all, or certain types of, medicare patients and encourage facilities to shift unreimbursed costs on to employees, employers and already overburdened State and local governments.

We believe no real health-care reform is possible until Congress enacts comprehensive, across-the-board cost-containment legislation along the lines of H.R. 3261. Currently, the Nation spends $322 billion for health care. In the absence of cost-containment legislation, health-care expenditures are projected to rise to $755 billion by 1990, which is roughly equivalent to what we are now spending for the entire Federal budget.

The AFL-CIO believes the H.R. 3261 offers a viable solution to this impending disaster. Furthermore, it would encourage States which meet Federal performance standards to make their own decisions about which form of prospective reimbursement should be used by all insurers, including medicare, to reimburse providers.

We urge Congress to immediately enact a comprehensive cost-containment program for all payors and including physician services. We stand ready and willing to work with the committee to achieve enactment of this legislation.

Chairman JACOBS. Thank you for your testimony.

[The prepared statement of Mr. Robert McGlotten follows:]

STATEMENT OF ROBERT MCGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION, AFL-CIO

The AFL-CIO is pleased to have the opportunity to testify in support of HR 3261. Organized labor has long been concerned about uncontrolled increases in health care costs. We vigorously supported comprehensive cost containment when it was last under consideration by the Congress and have given strong support to efforts to enact statewide cost containment systems. Our affiliates and local unions have made major efforts to control rising costs through collective bargaining and participation in local health care coalitions.

As you may know, representatives of organized labor and the Health Security Action Council have been very involved in the development of HR 3261, which we view as a substitute for cruel and arbitrary budget cuts and the only way to control the total rate of increase in health care costs.

Earlier this year Congress took a significant step towards reforming the health care reimbursement system by requiring hospitals which participate in Medicare to be paid on a prospective basis. Although we supported efforts to introduce the concept of prospective budgeting into the Medicare system and discontinue the practice of paying providers whatever they spend, we do not think Congress went far enough. In fact, many feel that the new payment system for Medicare will not fulfill expectations of reduced costs, improved program efficiency and protection for beneficiaries.

Without strong utilization controls, restraints on unnecessary hospital construction and coverage of physicians within the prospective rate, the cost of Medicare could continue to increase at double digit rates. In addition, the prospective reimbursement system for Medicare alone may give hospitals strong incentives to turn away all, or certain types of, Medicare patients and encourage facilities to shift unreimbursed costs onto employees, employers and already overburdened state and local governments.

No real health care reform is possible until Congress enacts comprehensive, across-the-board cost containment legislation along the lines of HR 3261. Currently, the nation spends $322 billion for health care. In the absense of cost containment legislation, health care expenditures are projected to rise to $755 billion by 1990, which is roughly equivalent to what we are now spending for the entire federal budget.

The AFL-CIO believes the HR 3261 offers a viable solution to this impending disaster. Furthermore, it would encourage states which meet federal performance standards to make their own decisions about which form of prospective reimbursement should be used by all insurers, including Medicare, to reimburse providers.

The AFL-CIO urges this Committee to be skeptical of those who blame our current health care crisis on those who work in and are served by the health care system. For until the providers and suppliers of health care services have real incentives for cost effective behavior, as a nation we will continue to pay a great deal more for less.

We urge Congress to immediately enact a comprehensive cost containment program for all payors and including physicians services. We stand ready and willing to work with the Committee to achieve enactment of this legislation.

Chairman JACOBS. Ms. Burch.

STATEMENT OF CHRISTINE CAPITO BURCH, LEGISLATIVE REPRESENTATIVE, AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO

Ms. BURCH. Mr. Chairman, I am here on behalf of our 1 million members, 300,000 of whom work in public health care facilities across the Nation. We thank you for holding these hearings and we strongly support this bill that has been introduced by our good friends, Senator Kennedy, Representatives Shannon and Mikulski.

Health care cost containment is a major issue for our union not just on a national policy level but every day when our local unions sit down to negotiate a contract and need to respond to employer demands for less health insurance at more expense to our members.

The employers of most AFSCME members, State and local governments, are in no position to be able to subsidize the health care industry's profligacy. State and local governments are still reeling from the double blow of the prolonged recession and the cuts in Federal aid.

Since the Reagan administration took office, States and localities have received $30.5 billion less in Federal assistance than they would have if existing policies had remained in effect. The operating deficits for the State and local sector, as a whole, averaged $2 billion in calendar year 1982.

For fiscal year 1983, 38 States cut spending and 36 States raised taxes or extended tax increases. The outlook for 1984 is not any better. According to information compiled by the National Governors' Association, 46 States have adopted or are considering one or more austerity measures for fiscal year 1984.

Mr. Chairman, unless immediate and concerted measures are initiated on a national scale, AFSCME's members who are employed may not be able to resist the employers' demands that they accept

inadequate health insurance or coverage requiring more copayments than they can afford. And more of our members who work in public health care facilities will be unemployed due to the State and local governments' inability to make up for Federal and private-sector cutbacks.

We would like to give you a few examples of our problems in our public facilities. Wayne County General Hospital, the only hospital in the Detroit area, is accumulating a $12 million deficit this year. Milwaukee General Hospital's deficit is $9.9 million. The hospital proposes to make up for that deficit by laying off 78 workers.

At Erie County Medical Center in Buffalo, patients qualifying for reduced rates based on income increased 96 percent from 1981 to 1982, and the number of patients involved in bankruptcy proceedings increased 25 percent.

There is one issue we would like to clarify, Mr. Chairman: Our members, the nonadministrative, nonsupervisory health care workers are not to blame for the continuing large increases in health care costs.

Payroll costs as a percentage of hospital costs decreased from 58 percent in 1970 to 49 percent in 1980. The average health care worker makes at least $1.70 an hour less than the average manufacturing worker. The average entry-level, yearly salaries of AFSCME members who work in hospitals look like this: laundry operators, $9,900; housekeepers, $12,700; and registered nurses at $16,400.

AFSCME believes health care costs can be equitably controlled in this country without restricting access to needed health care and without placing an unfair burden on health care workers.

The most important step Congress can take toward doing so would be enactment of the Health Care Cost Control Act of 1983 introduced in the House of Representatives by Representative James Shannon and in the Senate by Senator Edward Kennedy.

This legislation takes an approach toward cost containment designed to be effective without being cumbersome. All health care costs would be subject to limits on rates of increase, not just medicare costs, as currently, and not just hospital costs, as some States now do.

Representatives of health care workers would have input into the allowable rates of increase since health care workers are not responsible for driving up health care costs more than the consumer price index. Hospitals, like public hospitals, which serve disproportionate numbers of the poor would be eligible for special reimbursement for the bad debt and charity care they provide.

Given these guidelines, the legislation has the important feature of providing incentives for States to design their own cost containment systems. Health care costs need to be controlled across the board, but at the State level there are a lot of options as to exactly how costs should be controlled.

Health care delivery is very different from State to State. The amount and nature of the providers differ, as do the needs of the population. We see no reason why each State must control costs in exactly the same way, as long as certain principles are common to all States to assure equity.

We strongly support the provisions of H.R. 3261 that encourage the States to set up their own plan to control the rates of increase—not only for the hospitals but for the physicians as well. Mandatory assignment is the only way to make physicians sensitive to the unfair burdens of cost placed on the consumer.

In addition, the phaseout of return on equity will make the for-profit hospitals responsive to the needs of the consumer, rather than the dividends to the stockholder.

A national attack on rising health care costs is necessary to insure effectiveness, to prevent cost shifting and to insure that the burden of holding down costs is being shared proportionately by those responsible for the costs. This is not to say that all cost-containment efforts must be or are being intiated at the national level. Our union has been involved in a number of cost-containment initiatives which will hold down the costs for particular groups. There are brief descriptions of the approaches we are talking about on page 6 of our testimony.

There is a lot that can be done on the State and local level. But without clear Federal guidelines that apply to all providers, the efforts of our members will be wasted.

It is the responsibility of the Federal Government to make sure that cost-containment efforts are effective because they apply to all of those responsible for health care costs, not just those groups willing to voluntarily attack the problem.

We therefore urge the committee to favorably consider the provisions of H.R. 3261 rather than imposing further cuts in medicare.

Chairman JACOBS. Thank you, Ms. Burch.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL–CIO

Mr. Chairman, I am Christine Capito Burch and I am representing Gerald W. McEntee, International President of the American Federation of State, County and Municipal Employees. I am here on behalf of our one million members, including the 300,000 who work in public health care facilities across the nation.

A MAJOR AFSCME ISSUE

AFSCME thanks you, Mr. Chairman, for holding this hearing on H.R. 3261, the Health Care Cost Control Act of 1983. The continuing double digit rates of increase in health care costs, and the astronomical increases in health insurance costs, have made health care cost-containment a major issue for our union. No longer is health care cost-containment something which policy analysts, economists and a few legislators agree would be desirable to achieve. The issue dominates virtually all of our contract negotiations and has dominated the last two meetings of our Union's Executive Board. President McEntee has just appointed a special committee of the Executive Board to take expert testimony and recommend strategies the Union can follow to achieve cost-containment while protecting the benefits needed by our members to maintain their health.

Local AFSCME officers across the country have had to learn how to respond to employer demands for less health insurance at more expense to our members.

The employers of most AFSCME members, state and local governments, are in no position to be able to subsidize the health care industry's profligacy. State and local governments are still reeling from the double blow of the prolonged recession and the cuts in federal aid. Since the Reagan Administration took office, states and localities have received $30.5 billion less in federal assistance than they would have if existing policies had remained in effect. The operating deficits for the state and local sector as a whole average $2 billion in calendar year 1982. For fiscal year 1983, 38 states cut spending and 36 states raised taxes or extended tax increases. The outlook for 1984 is not any better. According to information compiled by the National

Governors' Association, 46 states have adopted or are considering one or more austerity measures for fiscal year 1984.

The fiscal plights of state and local governments, combined with increases in health care costs far in excess of the consumer price index, have spelled disaster for public health care facilities. Public facilities by definition must provide health care for all who need it regardless of their ability to pay. State and federal funding cutbacks and double-digit unemployment have made more individuals, without the ability to pay, dependent on public health care facilities, producing record deficits at these facilities.

For example, Wayne County General Hospital, the only public hospital in the Detroit metropolitan area, is accumulating a $12 million deficit this year. Milwaukee County General Hospital's deficit is $9.9 million. The hospital proposes to make up for that deficit by laying off 78 workers. At Erie County Medical Center in Buffalo, patients qualifying for reduced rates based on income increased 96 percent from 1981 to 1982 and the number of patients involved in bankruptcy proceedings increased 25 percent.

Mr. Chairman, unless immediate and concerted measures are initiated on a national scale, AFSCME's members who are employed may not be able to resist the employers' demands that they accept inadequate health insurance or coverage requiring more co-payments than they can afford. And more of our members who work in public health care facilities will be unemployed due to the state and local governments' inability to make up for federal and private-sector cutbacks. In either case the result will be the declining health of the population and increased demand on public health care facilities.

Before going any further, I would like to clarify one issue. Our members, the non-administrative, non-supervisory health care workers, are not to blame for the continuing large increases in health care costs. Payroll costs as a percentage of hospital costs decreased from 58 percent in 1970 to 49 percent in 1980. The average health care worker makes at least $1.70/hour less than the average manufacturing worker. The average entry-level, yearly salaries of AFSCME members who work in hospitals look like this: laundry operators, $9,900; housekeepers, $12,700, and registered nurses at $16,400. In Canada, the percentage of the gross national product spent on health care has not increased with national health insurance, but the percent of labor costs to total health care costs has increased, proving that you can hold down costs nation-wide while still allowing health care workers to improve their standard of living.

Our members are being victimized by physicians and hospital administrators who feel no compunction to restrain their costs. Surgery rates are now growing four to six times faster than the population. At least one-third of the hysterectomies and two-thirds of tonsillectomies are unnecessary. As federal health planning funds declined from $128 million in fiscal year 1981 to $65 million in fiscal year 1982, capital cost outlays in 35 states increased from $4 billion in 1979 to nearly $11 billion last year.

FEDERAL AND LOCAL ACTION NEEDED

AFSCME believes health care costs can be equitably controlled in this country without restricting access to needed health care and without placing an unfair burden on health care workers. The most important step Congress can take towards doing so would be enactment of the Health Care Cost Control Act of 1983 introduced in the House of Representatives by Representative James Shannon and in the Senate by Senator Edward Kennedy.

This legislation takes an approach towards cost-containment designed to be effective without being cumbersome. All health care costs would be subject to limits on rates of increase, not just Medicare costs as currently and not just hospital costs as some states now do. Representatives of health care workers would have input into the allowable rates of increase since health care workers are not responsible for driving up health care costs more than the consumer price index. Hospitals, like public hospitals, which serve disproportionate numbers of the poor would be eligible for special reimbursement for the bad debt and charity care they provide.

Given these guidelines, the legislation has the important feature of providing incentives for states to design their own cost containment systems. Health care costs need to be controlled across-the-board, but at the state level there are a lot of options as to exactly how costs should be controlled. Health care delivery is very different from state to state. The amount and nature of the providers differ, as do the needs of the population. We see no reason why each state must control costs in ex-

actly the same way, as long as certain principles are common to all states to assure equity.

We strongly support the provisions of H.R. 3261 that encourage the states to set up their own plan to control the rates of increase--not only for the hospitals but for physicians as well. Mandatory assignment is the only way to make physicians sensitive to the unfair burdens of cost placed on the consumer. In addition, the phase-out of return on equity will make the for-profit hospitals responsive to the needs of the consumer rather that the dividends to the stockholder.

A national attack on rising health care costs is necessary to ensure effectiveness, to prevent cost-shifting and to ensure that the burden of holding down costs is being shared proportionately by those responsible for the costs. This is not to say that all cost-containment efforts must be or are being initiated at the national level. Our Union has been involved in a number of cost-containment initiatives which will hold down the costs for particular groups. We will briefly describe for you some of the approaches we are taking.

ALTERNATIVE DELIVERY SYSTEMS

Health Maintenance Organizations—some of our recent negotiated settlements provide more financial incentives than in the past for members to join health maintenance organizations. Employer contributions for health insurance are geared to HMO rates, for example.

Preferred Provider Organizations—States like California, Wisconsin and Michigan have passed or are considering legislation to encourage PPO's. Representative Wyden has introduced similar federal legislation. Since PPO's are still paid on the basis of fee-for-service, PPO's must have a strong, independent utilization review component in order to keep costs down in the long run. Consumers need to be protected from PPO's hastily formed by providers eager to preserve fee-for-service without regard for the quality of care or the range of services provided. We support the PPO concept, if the PPO provide a broad range of services which meet the needs of specific groups and if utilization review plans a major role in the operation of the PPO.

We have had a particularly positive experience with Brackenridge public hospital in Austin, Texas serving as a PPO for Austin City employees. With the PPO arrangement, the hospital's occupancy rate increased from 81 to 100 percent and the number of city employees using the hospital from 10 to 67 percent. City workers benefit by not having to make co-payments otherwise required by their insurance. City hospital workers now enjoy increased job security and a stronger position at the bargaining table due to the hospital's improved financial condition. We would like to see more public health care facilities marketed to a broader population as PPO's.

PLAN REDESIGN

The cost of health insurance can be contained by redesigning insurance plans to provide incentives to avoid hospitalization whenever safe and practical. We try to negotiate the following kinds of changes in our members' insurance coverage: mandatory outpatient surgery for certain procedures, financial incentives for physicians to perform surgery in their offices, mandatory preadmissions, mandatory second surgical opinions, birthing center coverage, incentives for early discharge for maternity patients, promotion of home health care and hospice care, substance abuse treatment to treat the problem directly which otherwise creates serious illness, and financial incentives for patients to identify overcharges on their bills.

UTILIZATION REVIEW

The insurance companies are not totally blameless for the rate of health care cost increases. Insurance company officials admit that they are not reviewing utilization as required by their contracts with employers. The costs of inappropriate care are instead passed along to the consumers. One estimate, for Cambridge, Massachusetts, is that Blue Cross/Blue Shield's lack of utilization review costs the group of 3,600 $1½ million/year. Insurance companies also use padded utilization and inflation projections to hold onto premium monies longer. AFSCME, along with several other unions, is pursuing a strategy of filing State complaints to force the insurance companies to play a more active role in keeping down costs.

AFSCME is aggressively trying to contain health care costs. Our union is committed to preserving the access of those who need it to publicly-provided health care and to preserving the access of our membership to affordable health care. There is a

lot that can be done on the state and local level. But without clear federal guidelines that apply to all providers, the efforts of our members will be wasted. It is the responsibility of the Federal government to make sure that cost-containment efforts are effective because they apply to all of those responsible for health care costs, not just those groups willing to voluntarily attack the problem. We therefore urge the Committee to favorably consider the provisions of H.R. 3261 rather than imposing further cuts in Medicare.

Chairman JACOBS. Ms. Schoen.

STATEMENT OF CATHY SCHOEN, SPECIAL ASSISTANT TO THE PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION

Ms. SCHOEN. I am Cathy Schoen, special assistant to the president of the Service Employees International Union. On behalf of the 750,000 members and our president, John Sweeney, I thank you for holding these hearings.

The years since Congress last seriously considered and then rejected leadership in controlling costs have wreaked much damage. Cuts in health care benefits for publicly and privately insured and loss of all health insurance for millions of low income, unemployed families are now taking their toll in rising infant mortality rates and increasing evidence of postponed care causing unnecessary suffering and even death.

Yet, while benefits are cut in the name of saving money, new private fortunes are being made off of public and private health dollars. Corporate takeover and control of national health resources threatens further fragmentation of health markets to haves and have-nots.

Failure to act now and to put our national health resources back to work for people is likely to result in even more rapidly rising costs for a system willing to serve fewer and fewer people.

SEIU believes H.R. 3261 offers us a foundation to renew our national commitment to a humane and rational health system for patients and health care workers alike. Rather than review for you the specifics of H.R. 3261, however, we want to take our time today to highlight why we believe Federal legislation is necessary.

Our testimony is divided into four sections drawn from the experience of SEIU members in Canada and the United States working in and outside the health system in each country. I will briefly summarize and ask that the full statement be submitted for the record.

First, access cost control and decent working conditions are possible.

Canada provides us with a vivid national example that central public control of payment policies can at once achieve access, decent wages, and cost control. Canada has managed to hold almost constant the proportion of GNP spent on health care from 1971 to 1981—7.5 percent in 1971 to 7.9 percent in 1981. During the same period, the U.S. health system jumped from 7.8 to 9.8 percent of GNP.

Yet Canada at the same time expanded coverage to include all citizens with no direct patient payments at the time of care. In stark contrast, the proportion of uninsured in the United States has remained above 10 percent in the 1970's and is increasing rapidly in the 1980's.

SEIU Canadian members working in hospitals can attest to the rigors of cost controls. Yet, as documented in a recent New England Journal of Medicine article, Canadian cost controls have left ample room for improved wages and working conditions in the belief that decent patient care requires equitable treatment of health workers.

Average Canadian hospital worker wages have risen dramatically relative to industrial wages in Canada. Hospital workers' wages started out in the 1970's 16 percent below average industrial wages and rose to 17 percent above average industrial wages by 1980–81. This dramatic improvement in relative wages represents a 33-percent increase in real wages—wages adjusted for inflation.

Cost control, while allowing for wage improvements, has been possible in Canada through tight controls on the expansion of the health system and by tight controls of physicians' income. Canadian analysts repeatedly note that successful control has only been possible due to central, uniform payment policies for all patient groups.

Second, cost control requires Federal and private partnership roles.

Maintaining health benefits has become a major struggle in virtually every SEIU contract negotiation in the 1980's. We have recently been using our success in controlling costs in plans operated by several large SEIU locals to implement a national SEIU program for health plan cost containment. We have demonstrated our willingness in negotiations to work jointly with our employers as long as we agree that benefits will not be sacrificed to control costs.

In the SEIU experience, private efforts can achieve dramatic cost control successes despite insurance companies' seeming unwillingness to prescribe anything other than benefit cuts.

However, we believe that too often we succeed only at the expense of another group of workers and that our success is limited.

Providers have been able to shift costs and play each payor off against the other due to the lack of purchaser market power. Even our New York Local 32B–32J's health plan with 120,000 insured people has little system control in a city of 8 million. Our success in New York in controlling costs thus has depended critically on New York State cost control policies supporting our local efforts to redesign how we pay for care and what we pay for it.

Third, we believe the abdication by the Federal Government from unifying and leading national cost control efforts has directly supported a dramatic transformation of ownership and behavior in the U.S. health care system. The advent of corporate operation of health facilities for profit has both raised costs and limited access to care.

This transformation has occurred with little public fanfare. Large corporate health chains are rapidly buying up profitable segments of health care markets across the country by taking advantage of federally guaranteed returns on equity, full cost reimbursement, and an ability to shift costs at will. Standard analysis predicts that by 1990 profitmaking chains will control one out of five hospital beds—up from 6 percent in 1969, mainly single facility doctor hospitals.

The largest chain pulled in almost $3 billion in revenue in 1982 with a whopping 35-percent profit increase. Nursing home consolidation is even more startling. The largest chain already controls more than one in 20 beds nationally with forecasts predicting 30 percent by 1990 and total analysts predict the top five nursing home chains will control one-half of all nursing home beds in 1990. This chain alone reaped returns on equity four times higher than Fortune 500 in the State of Michigan last year.

It is clear from repeatedly rising and record-level profits that corporate health care is expensive health care. Recent studies support this conclusion. The studies indicate that profits come from higher charges for care rather than efficiency. Moreover, trends indicate an increasing tendency to segment markets into well insured, profitable patients and poorly insured money losers.

This massive consolidation of economic and political power has bid on and relied on a vacuum of leadership and control of payment policies. Chains notably avoid rate control States and remain in the fringes of other countries' markets.

At the same time, multi-State health care corporations necessitate Federal action for effective cost control. Individual State systems will need the common ground rules provided by H.R. 3261, to avoid being held hostage to the threat of runaway hospitals and nursing homes.

We believe this structural change is of such import that it deserves separate congressional hearings to focus public attention and debate on what legislative and regulatory changes may be necessary to protect national health care institutions.

Four, need to control capital and avoid antilabor bias.

In closing, we wish to point to a particular H.R. 3261 strength in its promotion of control of capital costs and avoidance of an antilabor bias.

The current low wages of U.S. hospital and nursing home workers offers perhaps the most vivid testimony that employers—with outside pressure—have their own internal incentives to seek to hold down health care workers' incomes.

Despite nearly 17 years of cost-based reimbursement—which assured a wage pass through to third-party payors—average hospital worker wages in the U.S. remained 22 percent below manufacturing wages as of 1982. Annual full-time hospital worker wages amount to less than $14,000 per year. Adjusted for inflation, hospital workers' incomes have actually decreased slightly since 1975 despite soaring hospital costs overall.

As a result, by 1981, total payroll costs in hospitals had declined to less than 49 percent—48.6 percent—of total hospital costs from 61.7 percent in 1965. This decline occurred in spite of a more than 50-percent increase in the number of employees per patient day during the same period.

We have attached a longer statement on the antilabor biases in the current system to our testimony. I am not going to refer to them here except to say that capital remains a passthrough while laborers control.

In summary, we support the bill and hope these hearings mark a revival to return to a Federal commitment for a human system for patients and workers.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, SUBMITTED BY CATHY SCHOEN, SPECIAL ASSISTANT TO THE PRESIDENT

Good morning. On behalf of the 750,000 members of the Service Employees International Union (SEIU) and our President, John J. Sweeney, I thank you for holding hearings on H.R. 3261. Throughout the nation, we see a critical need for Congress to enact legislation for effective, equitable control of public and private health care costs.

The years since Congress last seriously considered and then rejected leadership in controlling costs have wreaked much damage. Cuts in healthcare benefits for publically and privately insured and loss of all health insurance for millions of low income, unemployed families are now taking their toll in rising infant mortality rates and increasing evidence of postponed care causing unnecessary suffering and even death. For the most part, federal, state, and private insurance plans have merely shifted the financial burden for rising costs onto the shoulders of the sick and disabled or some other plan, rather than confronting cost control head on.

Yet, while benefits are cut in the name of saving money, new private fortunes are being made off of public and private health dollars. Corporate takeover and control of national health resources threatens further fragmentation of health markets to have's and have not's.

Failure to act now and to put our national health resources back to work for people is likely to result in even more rapidly rising costs for a system willing to serve fewer and fewer people.

SEIU believes H.R. 3261 offers us a foundation to renew our national commitment to a humane and rational health system for patients and health care workers alike. Rather than review for you the specifics of H.R. 3261, however, we want to take our time today to highlight why we believe federal legislation is necessary. Our testimony is divided into four sections drawn from the experience of SEIU members in Canada and the United States working in and outside the health system in each country: (1) Centralized Reimbursement Rules Can Achieve Access Cost Control and Decent Working Conditions; Cost Control Requires Federal and Private Partnership Roles; (3) Corporate Takeover and Fragmentation of Health Markets Is Both a Direct Result of Our Failure to Enact Cost Control and a Threat to our Ability to Control Costs in the Future; and (4) The Nation Needs to Control Capital and Avoid Anti-Labor Bias.

1. *Access Cost Control and Decent Working Conditions are Possible.*—Canada provides us with a vivid national example that central public control of payment policies can at once achieve access, decent wages, and cost control.

Canada has managed to hold almost constant the proportion of GNP spent on healthcare from 1971 to 1981—7.5 percent in 1971 to 7.9 percent in 1981. During the same period, the U.S. health system jumped from 7.8 percent to 9.8 percent of GNP.

Yet Canada at the same time expanded coverage to include all citizens with no direct patient payments at the time of care. In stark contrast, the proportion of uninsured in the U.S. has remained above 10 percent in the 1970's and is increasing rapidly in the 1980's.

SEIU Canadian members working in hospitals can attest to the rigors of cost controls. Yet as documented in a recent New England Journal of Medicine article, Canadian cost controls have left ample room for improved wages and working conditions in the belief that decent patient care requires equitable treatment of health workers. Average Canadian hospital worker wages have risen dramatically relative to industrial wages in Canada. Hospital workers' wages started out in the 1970's 16 percent below average industrial wages and rose to 17 percent above average industrial wages by 1980–81. This dramatic improvement in relative wages represents a 33 percent increase in "real" wages (wages adjusted for inflation).[1]

The relative wage and real wage improvements for Canadian health workers reflect improved wage equity in Canada. Canadian job evaluation, as in the U.S., has repeatedly indicated that hospital workers were underpaid considering the skill, responsibility, and efforts required. Canadian hospital cost controls have enabled increases where a case could be made for past inequities.

Cost control while allowing for wage improvements has been possible in Canada through tight controls on the expansion of the health system and by tight controls

[1]Allen S. Detsky, et al, "The Effectiveness of a Regulatory Strategy in Containing Hospital Costs, The Ontario Experience, 1967–1981," New England Journal of Medicine, July 21, 1983.

on physicians' income. Canadian analysts repeatedly note that successful control has only been possible due to central, uniform payment policies for all patient groups.[2]

2. *Cost Control Requires Federal and Private Partnership Roles.*—Maintaining health benefits has become a major struggle in virtually every SEIU contract negotiation in the 1980's. We have recently been using our success in controlling costs in plans operated by several large SEIU locals to implement a national SEIU program for health plan cost containment. We have demonstrated our willingness in negotiations to work jointly with our employers as long as we agree that benefits will not be sacrificed to control costs.

In the SEIU experience, private efforts can achieve dramatic cost control successes despite insurance companies' seeming unwillingness to prescribe anything other than benefit cuts. However, we believe that too often we succeed only at the expense of another group of workers and that our success is limited. Providers have been able to shift costs and play each payer off against the other due to the lack of purchaser market power. Even our New York Local 32B–32J's health plan with 120,000 insured people, has little system control in a city of 8 million. Our success in New York in controlling costs thus has depended critically on New York state cost control policies supporting our local efforts to redesign how we pay for care and what we pay for it.

Consequently, we conclude that private plan cost containment efforts requires united public and private reimbursement policies. Divided, we both lose.

3. *Transformation and Fragmentation.*—The abdication by the federal government from unifying and leading national cost control efforts had directly supported a dramatic transformation of ownership and behavior in the U.S. health care system. The advent of corporate operation of health facilities for profit has both raised costs and limited access to care.

This transformation has occurred with little public fanfare. Large corporate health chains are rapidly buying up profitable segments of health care markets across the country by taking advantage of federally guaranteed returns on equity, full cost reimbursement, and an ability to shift costs at will. Standard analysis predicts that by 1990 profit-making chains will control one out of five hospital beds—up from 6 percent in 1969, mainly single facility "doctor" hospitals.

The largest chain pulled in almost $3 billion in revenue in 1982 with a whopping 35 percent profit increase. Nursing home consolidation is even more startling. The largest chain already controls more than one in 20 beds nationally with forcasts predicting 30 percent by 1990 and total analysts predict the top five nursing home chains will control one half of all nursing home beds in 1990. This chain alone reaped returns on equity four times higher than Fortune 500 in the state of Michigan last year.

It is clear from repeatedly rising and record-level profits that corporate health care is expensive health care. Recent studies support this conclusion. The studies indicate that profits come from higher charges for care rather than efficiency. Moreover, trends indicate an increasing tendency to segment markets into well insured, profitable patients and poorly insured money losers.

This massive consolidation of economic and political power has bid on and relied on a vacuum of leadership and control of payment policies. Chains notably avoid rate control states and remain in the fringes of other countries' markets.

At the same time, multi-state health care corporations necessitate federal action for effective cost control. Individual state systems will need the common ground rules provided by H.R. 3261, to avoid being held hostage to the threat of "runaway" hospitals and nursing homes.

We believe this structural change is of such import that it deserves separate Congressional hearings to focus public attention and debate on what legislative and regulatory changes may be necessary to protect national healthcare institutions.

4. *Need to Control Capital and Avoid Anti-labor Bias.*—In closing, we wish to point to a particular H.R. 3261 strength in its promotion of control of capital costs and avoidance of an anti-labor bias.

The current low wages of U.S. hospital and nursing home workers offeres perhaps the most vivid testimony that employers—without outside pressure—have their own internal incentives to seek to hold down health care worker's incomes. Despite nearly 17 years of cost-based reimbursement (which assured a wage pass through to third party payors), average hospital worker wages in the U.S. remained 22 percent below manufacturing wages as of 1982. Annual full-time hospital worker wages

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[2] Robert G. Evans, "Healthcare in Canada: Patterns of Funding and Regulation," Journal of Health Politics, Policies, and Law, V8 (1), Spring 1983.

amount to less than $14,000.00 per year. Adjusted for inflation, hospital workers' incomes have actually decreased slightly since 1975 despite soaring hospital costs overall.

As a result, by 1981 total payroll costs in hospitals had declined to less than 49 percent (48.6 percent) of total hospital costs from 61.7 percent in 1965. This decline occurred in spite of a more than 50 percent increase in the number of employees per patient day during the same period.

Non-supervisory workers' wages today come to less than 37 percent of total hospital costs. In other words, a 10 percent increase in non-supervisory workers' wages would contribute roughly a 3 percent increase to hospital costs per day. We have attached an SEIU paper which details the biased current federal policies which encourages further shifts away from labor to capital. For example, current § 223 and DRG regulations allow hospitals to pass through capital expenses while limiting labor expenses. This policy in effect makes capital a risk free budget item while labor is a drain on hospital administrators' budgets.

Hospitals respond to such incentives to the detriment of health workers and patients. In hospital after hospital, SEIU locals report wage freezes, benefit cuts, layoffs, and a substitution of part-time employees for formerly full-time jobs. For example, full-time RN's were down 1.2 percent from 1980 to 1981, while part-time RN's increased by 12 percent.

Notably the only major category of hospital employee to show rapid increases in employment has been in the administrator and assistant administrator category. Jobs in this category jumped by 28 percent from 1980 to 1981. Apparently the current U.S. maze of reimbursement systems is now pulling workers out of patient care while increasing the size of hospital central paperwork bureaucracies.

Instead of rational staff planning including attempts to define minimum staffing necessary for care, SEIU locals are seeing frantic scrambles to cut staff in an effort to maintain business as usual when it comes to expansion and duplicative purchases of new technology.

H.R. 3261 would help to halt this irrational cost and healthcare policy. The bill would institute hospitalwide and communitywide budget targets across all cost categories and all payers. Special attention is given to enable hospitals to maintain adequate staffing for patient needs and to pay equitable wages.

We urge Congress, whatever the fate of H.R. 3261, to remove the current anti-labor bias in federal policies.

In summary, SEIU supports federal leadership and requirements for a systemwide approach to health cost containment. We hope these hearings mark a revival of a federal commitment to a humane system for patients and workers. We look forward to working with you in the future. Thank you.

REMARKS BY CATHY SCHOEN ON BEHALF OF JOHN J. SWEENEY, PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, FOR THE PANEL ON HOSPITAL FINANCING: EFFECT OF TEFRA AND IMPLICATIONS FOR THE FUTURE; "WILL PATIENTS AND HOSPITAL WORKERS BE HURT?"—GOVERNMENT RESEARCH CORP.'S EIGHTH ANNUAL LEADERSHIP CONFERENCE ON HEALTH POLICY, JUNE 16, 1983, WASHINGTON, D.C.

Good afternoon, I am delighted to be here today representing John J. Sweeney, President of the Service Employees International Union.

We are here today representing the nation's health workers and consumers. Of SEIU's 750,000 members, roughly one quarter of a million work in hospitals and nursing homes nationwide.

We have been asked to direct our remarks to the impact of recent federal health policy changes on hospital workers. However, throughout SEIU's local unions and at the International we find that any discussion of health care workers requires a broader focus of what is happening to patient care and communities. In city after city, hospital and nursing home workers find it impossible to separate questions of working conditions from questions of patient and community welfare.

I. HEALTH CARE WORKERS: A VITAL NATIONAL RESOURCE

Before outlining what we see happening as a result of recent policy changes, I want to take a few minutes to describe the hospital workforce and working conditions—a world which rarely gets publicity.

The glamor and billion dollar public image hides a reality in which nearly 3 million workers work for low wages under stressful and hazardous working conditions.

The hospital industry has historically profitted from social and economic discrimination in the general society which has held down the wages of women and minorities. Although theoretically today's laws prohibit sex, race or ethnic discrimina-

tions, most health care jobs remain "women's" work and depend heavily on racial and ethnic minorities.

Eight out of ten hospital workers are women. Minorities are 20 percent of hospital workers overall—and one third to one half of hospital service workers.

Hospital workers' wages, despite marked progress due to unionization, remain, below national average wages and 22 percent below manufacturing wages. Average annual wages today came to $13,444 (including all staff up to top level administrators.

If adjusted for relative skills and years of training, the gaps grow wider.

In inner city and rural communities across the country, hospitals are often the major employers, supporting numerous smaller business—restaurants, supply companies, labs, banks, hotels, etc—as well as directly providing vital jobs and incomes. Thus, the continued exploitation of the hospital workforce acts to hold down the living standard of entire neighborhoods.

Despite ample evidence of low pay and difficult working conditions, some policy makers and industry managers assert labor costs account for run away health costs and conclude that cost containment must come out of sacrifices from the workforce.

A few simple facts give lie to these claims:

If the hospital costs had been held to the same increases as payroll costs per workers from 1975 to 1981, total national spending on hospital care would today be 25 percent lower. Wages adjusted for inflation have declined.

In fact, labor costs have taken a smaller and smaller share of total hospital budgets. From 1965 to 1981, payroll costs declined from 62 percent of total expenditures to 49 percent. Fringe benefit costs declined at similar rates.) This dramatic reduction occurred despite a 55 percent expansion in the number of employees per patient due to technological advances requiring more intense levels of service.

These are total payroll costs—including supervisory, physician, dentists, residents and interns salaries.

Rough adjustments put nonsupervisory costs at less than 40 percent of total costs. This means that a 10 percent increase in wages of nonsupervisory workers would produce less than a 4 percent increase in the costs per patient day, given the same level of services.

Total labor costs hide the growing gap between wages of top hospital administrators and supervisors and nonsupervisory employees.

Industry magazines applaud what they see as a consistent new trend for the top "corporate executive officers" earnings to outpace general inflation. To quote a recent article,

"The 4.3 point differential between the vise in the BLS cost of living measure and the rise in hospital management salaries is good news"—Modern Health Care, December 1982, Compensation Survey.

Perhaps the most telling evidence that labor costs do not determine total costs trends is the fact that costs and wage across cities bear little relation to each other. For example, Houston hospital costs per capita in 1982 averaged $743, seven percent above average per capita costs in New York. Yet New York payroll costs per employee were 34 percent above Houston costs—a $2,700 annual difference. A table accompanying our remarks shows similar discrepancies across the 10 largest US cities.

II. CONDITIONS WORSEN FOLLOWING TEFRA

We are seeing indications that federal and state policy will rapidly worsen wages and working conditions to the detriment of patients, workers and low income communities.

We see this threat resulting from three specific characteristics of recent policy, rather than a necessary by product of any effort to contain costs.

(1) Public program cuts in coverage and benefits in the face of severe recession are putting institutions serving large numbers of low income and senior citizens in financial jeopardy. This stress on inner city (public and non profit institutions) and rural hospital in low income communities hits are and staff of these institutions inequitably and spills over to hurt the general welfare of low income communities.

(2) Recent reimbursement encourage substitution of capital for labor even when this results in higher total costs.

(3) Reimbursement policies favor (whether by design, or accident) the consolidation of hospital resources into profit making corporations. We are seeing clear indications that corporations generate profits by reducing patient care staff, and focusing on more affluent patient care markets; not by reducing the total costs of care to the community.

Some brief comments and evidence on each of these impacts:

1. *Worsening patient care and working conditions in inner city and rural hospitals in low-income communities.*—Around the country SEIU local unions report layoffs, and reduced staff to patient ratios in hospitals serving large numbers of public program beneficiaries. The problem is particularly severe in those cities, like Detroit, suffering from high levels of unemployment with consequent loss of private insurance. Unlike previous recessions, the Medicaid program is contracting rather than expanding to help cover the health needs of workers while unemployed. Medicaid rolls nationwide have remained roughly constant despite a jump percentage of the poverty population and record unemployment rates.

A few snapshots from SEIU experience around the country help illustrate emerging trends:

San Francisco and bay area

One hospital has closed, nine hospitals have laid off nursing, dietary and housekeeping staff; and hospitals claim this is just the beginning.

Our local union also reports that budget cuts and layoffs have hospitals in combat with each other, with continued attempts to vie for private pay patients with new services and expanded facilities.

Kansas City

The major public hospital, Truman Medical Center has laid off 120 employees, despite a 16 percent increase in patient days.

Two nonprofit facilities have laid off 140 and 120 workers each, yet at the same time are undertaking major capital projects.

While layoffs among patient care staff are common across the city, there have been no administrative layoffs yet in SEIU facilities.

Youngstown, Ohio

Three SEIU nonprofit hospitals have laid off 140 workers out of a 1,500 worker unit.

At the same time, there have been no administrative staff cuts and administrative personnel received an 8 percent wage increase in December.

The hospitals also are planning new intensive care and coronary care units; occupancy rates are high.

Boston and surrounding areas

Massachusetts hospitals have uniformly responded to a new rate setting laws with layoffs.

The Hospital Association expects a 3,000 job reduction this year—with cuts from nurses on down.

SEIU reports layoffs are particularly concentrated in licensed practical nurses and aides, despite increases in equipment purchases and new capital construction projects.

We have attached a table to our prepared remarks which document an emerging trend to expand administrative staff while contracting patients care even before TEFRA and major recession impact. From 1980 to 1981 community hospitals increased administrators by nearly 30 percent, yet reduced full time nurses, eliminated nurse vacancy positions and shifted to a more part time staff.

Nationwide nursing surveys reveal this trend accelerating in 1982 and 1983. Across the states, city hospitals are lowering standards of nursing care—the much publicized nursing shortage is disappearing merely redefining downward acceptable staffing ratios.

In addition, many hospitals are lying off two licensed practical nurses and nursing aides for every temporary registered nurse added to staff. If trends continue, entry level nursing jobs in hospitals may soon be eliminated.

From a social and economic perspective, this is an irrational workforce policy. We are losing still a valuable and experienced nurse workforce; eliminating the possibility of creating on the job career mobility; and destroying job opportunities in nursing for those workers willing to learn new skills in health industry yet whose incomes prohibit them from first going the route of four years of college. The result will be even more rigid occupational barriers which discriminate by race and social and economic class.

Currently, only the low wages of registered nurses allow hospitals to begin to rationalize using highly skilled nursing staff for even the most routine and menial tasks. Meanwhile an experienced, disproportionately minority nurse staff is joining the ranks of the unemployed.

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ANTILABOR BIAS DESPITE HIGHER COSTS

TEFRA, the new DRG system, and many state rate systems, irrationally encourage hospitals to substitute capital for labor. By continuing to pay all capital costs (depreciation, interest, rent and return on equity costs) while limiting operating costs (largely labor) policies transform labor costs into a drain on hospital budgets, and capital into a revenue producer and generator of funds for expansion. A recent, May 6 report by the Congressional Budget Office notes:

"Hospitals will have an incentive to pursue labor saving investments even when they increase total costs".

These are bizarre incentives in a system criticized for years for over expenditures on hospital facilities and equipment, yet, rarely, if ever, criticized for providing too much patient care, overly nutritious meals, or an excess of housekeeping staff and cleanliness.

SEIU locals are seeing this incentive played out in city after city. Layoffs are accompanied by hospitals expanding and adding new services, or more expensive services—with little attention to whether the equipment will duplicate a neighboring hospital's facilities.

CORPORATIZATION OF HEALTH CARE

By making it increasingly difficult to survive with large proportions of Medicare and Medicaid patients, and by giving financial incentives to substitute capital for labor irrespective of the impact on total costs, current policy supports and enhances the market position of billion dollar for profit health corporations. These corporations are both willing and able to acquire facilities in more affluent communities and to drive down staffing standards if the result is higher profits.

With access to the stockmarket, and an ability to pull out of communities which fail to yield desired profit margins, large corporate hospital chains realized a whopping 52 percent increase in profits in 1982—a year of major health program cuts and severe recession. In the same year, public hospital system multi-hospital public systems lost $32 million despite increasing occupancy rates.

Standard analysis now predicts that by 1990 for profit hospital chains (investor owned) will control twenty percent of the hospital resources, up from 6 percent of beds in all for-profit hospitals (chains and individual hospitals) in 1969.

The chains are growing largely by buying up hospitals around the country, rather than an overall expansion of the industry. Recent trade magazines even extolled the virtue of acquiring public hospitals from counties and municipalities desperate for short run revenue.

One of the first actions of new management is to cut staff, raise patient charges, adopt new billing practices which speed collections and screen patients to determine ability to pay.

For hospital workers, the result is more patients per person, at times wage freezes, and a new emphasis on generating profits for the corporation rather than doing the most for patients.

Hospital association statistics reveal that on average for-profit hospitals spend a mere 40 percent of their total budget on payroll costs versus 49 percent of budget for payroll industrywide.

We question whether the current pressure to compete with nonprofit hospitals for patients by maintaining standards of care will continue as corporations consolidate economic and political power.

Analysts predict a new surge in growth as Medicare converts to a diagnosis related system. Hospitals focusing on patients with less than average resource needs per diagnosis—by avoiding low income patients and frail, super-seniors—and willing to lower standards of care, stand to make windfall profits under this new prospective system. Unlike the previous cost based system, cutting staff will directly produce profits.

Yet, captial costs—as in TEFRA—will continue to be reimbursed at full costs, however unnecessary or duplicative.

SUMMARY

All three current policy trends threaten hospital workers patient care, and lower-income communities.

SEIU along with others concerned with access to care and quality of care, as well as costs, are now struggling to counteract a reversal of past progress toward a more humane system health system.

We already see a growing militancy as hospital workers are pushed against the wall by frozen, poverty wages and staffing shortages. We have not had to resort often to strikes in the past. This will change if policy fails to change to acknowledge the right to decent working conditions and service to the community, and to safeguard the Nation's health.

We as a nation must focus efforts to contain costs on waste, duplication of services and ineffective care. If we, instead, make it impossible for over-worked underpaid for hospital staff to deliver compassionate health promoting care, we all will suffer. Health care without people—involved and committed people—is simply not care.

Chairman JACOBS. Mr. Killeen.

STATEMENT OF PATRICK KILLEEN, SENIOR HEALTH CARE CONSULTANT, SOCIAL SECURITY DEPARTMENT, INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UNITED AUTO WORKERS

Mr. KILLEEN. Thank you, Mr. Chairman.

My name is Patrick Killeen, senior health care consultant in the UAW Social Security Department. We would like to submit our written statement for the record, and I will summarize some of the key elements.

I appear today on behalf of the more than 1½ million active and retired UAW workers and their families. We appreciate the opportunity to present our views on the issue of health care cost containment.

We urge Congress to come to grips with this most vexing national concern.

The UAW commends Representatives Shannon and Mikulski for their initiative in sponsoring the Health Care Cost Control Act of 1983, H.R. 3261. We strongly support this legislation as a positive approach toward controlling rising health care costs.

Escalating costs of health care services are acting as a drag on the Nation's economic recovery, straining government budgets and erecting roadblocks to orderly collective bargaining. Employers continue to rely on a combination of health care inflation and the still-lingering effects of the economic recession to justify demands on unions to reduce existing health care benefits.

Government procurement officials have added fuel to the fire by misguided efforts to influence collective bargaining, threatening to punish contractors who fail to reduce employee health care benefits in a manner satisfactory to those officials.

The costs of maintaining health insurance coverage for most UAW members has escalated greatly. We are seeing the costs of our health care benefits double every 5 years. The costs of our health care program at General Motors in 1981, for example, was about $2 per employee hour worked and in 1982, that rose to $2.50 per hour. These costs are higher than they should be and represent an unnecessary burden in collective bargaining.

We are well aware of the current efforts by the Reagan administration, by some employer groups, and by certain conservative researchers to plant and cultivate the simplistic belief that the way to deal effectively with the problems of the health care system is to force the American people to pay more, to do without, to use less, and to price shop for health services. The UAW, for one, will not buy that approach of blaming the victims for the problem.

We believe that health care inflation has multiple interrelated causes and cannot be dealt with in a simplistic manner.

We have participated in a variety of efforts in the private sector to find vehicles to contain costs in the current system and structure. These include development and encouragement of health maintenance organizations, especially prepaid groups, the introduction to health insurance programs of administrative procedures such as concurrent hospitalization review, preauthorization for services, second surgical opinion programs and a number of other programs.

Our experience with HMO's have been somewhat encouraging. We also have been participating with the major auto companies on joint committees to help contain health care costs.

We have hopes for these efforts and we believe they will generate some modest savings, but our extensive experience has also led us to conclude that we cannot solve this problem with our fragmented private sector responses. Strong public action is required.

This has been acutely evident especially since the defeat of the Carter administration's cost containment program. We believe that Congress must not further postpone action on this critical issue.

We are convinced that the Health Care Cost Control Act of 1983 represents a constructive and workable approach to controlling escalating health care costs. It certainly is a positive alternative to the Reagan administration's punish-the-consumer approach.

This bill is not the full answer to our Nation's problems. There is still a need to get on with providing health care coverage for the millions of Americans who are unemployed. The UAW also remains firmly committed to the goal of a comprehensive national health insurance system.

H.R. 3261, however, is a major first step in addressing the systematic problems of rising health care costs.

On behalf of the UAW, therefore, we urge the members of the committee to support this critically important legislation.

Thank you.

Chairman JACOBS. Thank you, Mr. Killeen.

Mr. Shannon?

Mr. SHANNON. No questions, Mr. Chairman.

I thank you all for your testimony and look forward to working with you and all of your organizations as this legislation progresses.

Thank you, Mr. Chairman.

Mr. RANGEL. I just want to thank you and hope that you can remind your principles that we are in a great struggle and we are going to need not only members but their names on a piece of legislation and have labor identified with it. If this is going to be a serious thrust, then we are going to have to network by reaching out beyond the political circles and the labor circles, because this is the first time that we are attempting to fight back and some of us just get tired of losing, because it is an exciting idea.

So you can depend on the support of the members that you know.

The question is, after you get that, then where do you go? So we will have meetings to develop a strategy to see how we can get some priority for the bill.

Ms. IGNAGNI. Congressman, on behalf of organized labor, I think that I can assure you that the support will be there.

Chairman JACOBS. Mrs. Ignagni, I can assure you that so far today you are ahead in the contest for the $1 reward for the most concise testimony and way ahead. You have two competitors to go. We will see what happens.

Thank you for your contribution to the record.

[The prepared statement follows:]

STATEMENT OF PATRICK F. KILLEEN, SENIOR HEALTH CARE CONSULTANT, SOCIAL SECURITY DEPARTMENT, IN BEHALF OF INTERNATIONAL UNION, UNITED AUTOMOBILE AEROSPACE & AGRICULTURAL IMPLEMENT WORKERS OF AMERICA, UAW

Mr. Chairman, my name is Patrick Killeen. I am Senior Health Care Consultant in the UAW Social Security Department. I appear today on behalf of the more than 1½ million active and retired UAW members and their families.

We appreciate the opportunity to present our views on the issue of health care cost containment. We urge Congress to come to grips with this most vexing national concern.

The UAW commends Representatives Shannon and Mikulski for their initiative in sponsoring The Health Care Cost Control Act of 1983 (H.R. 3261). We strongly support this legislation as a positive approach towards controlling rising health care costs.

Hardly anyone would disagree with the proposition that this nation has an urgent need to contain escalating health care costs. It is evident that the rate if increase in prices for most goods and services has slowed considerably over the past year-and-a-half, but health care prices have not followed that trend. Except for an occasional move sidewise in one or another geographic location, they appear to be increasing at a rate that is 2½ to 3 times faster than prices generally.

Last year, Americans spent $322.0 billion for health care, up 12.5 percent from the previous year. Health care expenditures now represent 10.5 percent of the gross national product (GNP). Worse still, the informed prognosis seems to be that 1990 will find us pouring 12 percent GNP into health care, unless something is done. It is somewhat difficult to recall now why we were dissatisfied—as we were—with the performance of the health care sector in 1965 when it consumed about 6 percent of (a much smaller) GNP.

Although there are millions of Americans who lack effective access to needed health care services, it is rather unsettling to observe that health care is widely preceived as a bottomless pit that swollows up whatever resources we are able to commit to it without improving the health status of the public at large.

In fact, escalating costs of health services are acting as a drag on the nation's economic recovery, straining governmental budgets and erecting roadblocks to orderly collective bargaining. Employers continue to rely on the combination of health care inflation and the still lingering effects of economic recession to justify demands on unions to reduce existing health care benefits. Government procurement officials have added fuel to the fire by misguided efforts to influence collective bargaining, threatining to punish contractors who fail to reduce employee health care benefits in a manner satisfactory to those officials.

The cost of maintaining health insurance coverage for most UAW members has escalated greatly. We are seeing the cost of our health benefits double every five years. The cost of our health care program at General Motors in 1981, for example, was about $2.00 per employee hour worked and in 1982, $2.50. A significant portion of the added cost can be attributed to the expenditures involved in providing coverage for those laid off, and the depleted active employee base to support those costs, as well as the cost of retiree coverage. These costs will be less onerous as employment levels increase. Nevertheless, the costs are higher than they should be, and represent an unnecessary burden in collective bargaining.

There is enormous pressure from all sectors of the economy, including the labor movement, to control health care inflation. The UAW will continue to support constructive approaches such as H.R. 3261. And we will continue to resist aggressively efforts, whether legislative or in collective bargaining, that purport to deal with the health care cost problem by treating our current predicament as something that developed overnight and as something to be cured with a quick fix. We are not persuaded that this nation can achieve any lasting solution by forcing general reductions in existing health care benefits, transferring more of the costs to workers, or

imposing a "tax cap" on health insurance premiums. Nor will we passively acquiesce in the efforts of the Reagan Administration aimed at gradually dismantling public health care programs, like Medicare, for the sake of "cost containment" to the disadvantage of older persons, the disabled, the unemployed, and others to weak to fight back.

We are not willing to equate cost transfers—in the form of higher copays and deductibles, or additional benefit limitations and restrictions—with reasonable cost containment efforts, in either public or private health care programs. Cost containment has meaning only as it reflects everyone's costs. The notion that stabilizing government's or employers' health insurance outlays—while the public at large, including UAW members, is placed at increasing personal risk—is nothing other than cost shifting. In fact, real cost containment recognizes that the problems are systemic and that it is illusory to expect any success in controlling costs without also restraining the prices of services and their use, and taking steps to restructure provider incentives.

We are well aware of current efforts by the Reagan Administration, some employer groups, a few area health care coalitions lacking a broad community base, and assorted conservative researchers to plant and cultivate the simplistic belief that the way to deal effectively with the problems of the health care system is to force the American people to pay more, do without, use less and price shop for health services. The UAW, for one, will not buy that approach of blaming the victims for the problem.

We believe that health care inflation has multiple, interrelated causes. Increases in aggregate health care expenditures are attributable to price increases for medical services, population growth and aging, developments in medical technology, an inefficient health care delivery system, inflationary payment methods, and the absence of a national health plan with budgeted expenditure ceilings.

We also believe that:

With the kind of health insurance available to industrial workers in the real world (with benefit restrictions and significant patient cost sharing already built in), it is difficult to understand how further benefit reductions would favorably impact on the prices of services. Indeed, if providers regard direct consumer payments as a potential additional source of funds, it is even conceivable that putting consumers at greater personal financial risk could be counterproductive and increase inflationary pressures.

It is possible to find ways of increasing provider accountability and responsiveness to patient needs and public goals without laying the entire responsibility for achieving the provision of cost-effective health care services on the patient's pocketbook.

There is evidence that increasing patient cost sharing and otherwise restricting benefits under health insurance will adversely affect the health status of individuals and reduce access to quality care. Also, any such adverse effects will be concentrated disproportionately among lower-paid and blue collar workers.

Prospective budgeting for hospitals under Medicare in the form of fixed payment rates for several hundred "diagnosis-related groups" (DRGs) represents a major departure from traditional, inflationary, retrospective cost reimbursement. However, several potentially negative outcomes including transferring costs from Medicare to all other payers, opening the door to private hospital "dumping" of sicker patients, and manipulating diagnoses and increasing the number of admissions to maximize hospital income, need to be avoided to maintain quality of care and to control inflation of hospital costs. And this program applies only to Medicare, not all payers for hospital services.

There have been a variety of efforts by private sector groups to find vehicles to contain costs within the current system and structure. The UAW has been a vigorous participant in these activities. These include the development and encouragement of health maintenance organizations (HMOs), especially prepaid groups, the introduction to health insurance programs of administrative procedures such as concurrent hospital review, preauthorization, second surgical opinions, utilization review activities, generic drug programs, encouragement of ambulatory surgery and other programs to monitor and begin to change the wasteful way medicine is practiced.

UAW experience with HMO's has been somewhat encouraging. We have been advocates of HMO's, and have had dual choice options for HMOs in our agreements with major employers, for more than 30 years. We have our own approval procedure (separate from the Federal HMO qualification program) and have approved more than 60 plans in which UAW members are enrolled across the country. Although we have not made a comprehensive analysis of savings achieved through HMO enrollment, an estimate based on enrollments of General Motors workers in four (4)

states with substantial HMO populations suggests an average savings over traditional health insurance coverage of about 20 percent. While we note continued growth in the percentage of members choosing HMO's, we still do not foresee, in the near future, HMO's replacing traditional coverage for a majority of our members.

Our Union also has been participating in actively functioning joint committees responsible for health care cost containment with each of the auto manufacturers. The committees initially undertook a number of pilot programs, but have recently begun to move more aggressively with programs of larger scope designed to elicit more cost-effective use of health care resources, without unnecessarily disturbing existing patient-doctor choice or exposing patients to added financial burdens. Many of the programs are too new to have a track record, but we can point to a few instances in which we have seen tangible savings, such as a preauthorization program for selected kinds of foot surgery for Chrysler workers in Michigan, as well as a plan for encouraging use of lower cost, generic equivalent prescription drugs.

We have hopes for these efforts and believe they will generate modest savings. But our extensive experience also has led us to conclude that we cannot solve this problem with our fragmented private sector responses. Strong public action is required. This has been acutely evident since the defeat of the Carter Administration's hospital cost containment program. We believe that Congress must not further postpone action on this critical issue. We are convinced that the Health Care Cost Control Act of 1983 (H.R. 3261) represents a constructive and workable approach to controlling escalating health care costs. It is certainly a positive alternative to the Reagan Administration's "punish the consumer" approach.

H.R. 3261 has a number of important elements which we believe make it an effective instrument for restraining rampant medical care inflation:

It would apply to all payers of health care services, thereby preventing cost shifting or payment differentials that are not justified by economic considerations.

It would place immediate "caps" on hospital revenues, physician fee increases, and outpatient charges for diagnostic x-ray and laboratory tests and other services. This would immediately restrain health care inflation, while allowing state governments up to two years to devise their own cost containment programs.

After this initial phase, the states would be responsible for implementing cost containment programs of their own, based on prospective budgets and negotiated payment arrangements for hospitals, doctors, and other health care providers. The states would be given considerable flexibility in designing and operating their programs as long as they meet broad federal guidelines and nationally established cost containment goals.

States with effective cost containment programs would receive a two-percentage point increase in the federal match for funding state Medicaid programs for the needy. This represents a significant positive incentive to establish such programs.

If a state failed to establish a program, however, the federal government would step in and administer cost limitations.

An Advisory Committee on Health Care Technologies and Procedures would be established to review whether and under what circumstances reimbursement would be allowed for various types of providers and services.

We urge this Committee to study this bill in detail. We believe it will go a long way toward putting the brakes on medical care inflation. We are willing to work with the Members and staff of this Committee to improve and refine the bill.

H.R. 3161 is not the full answer to our nation's health care problems. There is still a need to get on with providing health care coverage for the millions of Americans who are unemployed. The UAW remains committed to the goal of a comprehensive national health insurance system. H.R. 3261 is, however, a major first step towards addressing the systemic problems of rising health care costs. On behalf of the UAW, therefore, I urge the Members of the Committee to support this critically important legislation.

Chairman JACOBS. The final panel for the day, National Consumers League and National Farmers Union.

Ms. Warden, you are listed first. Proceed in your own fashion right up to 5 minutes.

STATEMENT OF BARBARA WARDEN, EXECUTIVE DIRECTOR, NATIONAL CONSUMERS LEAGUE

Ms. WARDEN. Thank you very much, Mr. Chairman. In the interest of time, I would like to shorten my statement, but ask that the full statement be included in the record.

Chairman Jacobs and members of this subcommittee, I am the executive director of the National Consumers League. I want to thank you for giving me an opportunity to testify before the subcommittee on the subject of health care cost containment.

This subcommittee has undertaken a most difficult assignment in considering H.R. 3261, the Health Care Cost Control Act of 1983, which the league endorses. Though this legislation provides a constructive approach to addressing one of the most perplexing and difficult problems of our era, escalating health care costs, its enactment will be an uphill struggle.

By examining ways to control health care costs, you are challenging the domain of a deeply entrenched, extremely well financed, and very influential sector of our economy, the health care industry. It is a formidable task. Earlier Congresses and the executive branch have failed to reach a solution, but the problems must be tackled if Americans are not to be priced out of their health care system.

The league believes that in many ways our health care system has been stood on its head. Rather than having consumers as the center around which our health care system revolves, consumers have become the forgotten element in the health care equation.

Our health care system is a complex and peculiar service industry of diverse providers—private practitioners, hospital-based or free-standing medical groups, Health Security Action Council-based or outpatient clinics and emergency rooms, community health centers, health maintenance organizations, nursing homes, and hospice centers—which can dictate the accessibility, cost, and types of services available.

Health care is our Nation's second largest employer with over 6 million people employed in the health care field. In 1982, America's national health bill totaled $322 billion, a levy of about $1,400 on every man, woman, and child in our country, constituting about 10 percent of our gross national product.

Last year medicare and medicaid paid $82.7 billion for health care services for beneficiaries. This year, U.S. companies will pay $77 billion in health insurance premiums for their employees, retirees and dependents, more than those companies will pay out in dividends.

By any measure you use, the health care industry is big business. But it is a business whose structure is unique to our free market economy in that demand is not set by the buyer, but by the very people who supply the services. The present suppliers of health care services are largely unrestrained by the traditional marketplace characteristics of quality comparison, truth in labeling information, price competition, information disclosure, and informed consumer consent.

Normally, it is the buyer who decides what service or commodity to purchase, whether it is a haircut or a lawnmower. In medicine,

there is a peculiar relationship between the buyer and the seller. Decisions are made mostly by the seller, that is, the physician. The physician as a businessperson is one of the few American entrepreneurs who has the power to influence, if not determine, the level of demand for his or her services.

In contrast to the dominant position providers have assumed in our health care system, consumers have been relegated to the role of unenlightened and unassertive, but grateful, fearful and compliant dependents. Consumers have been cut adrift from most of the decisionmaking about their own health care. Consumers have been discouraged from inquiring about physician and hospital fees, or about basic services and procedures.

Though health care costs have been identified in surveys as the public's primary health concern, consumers have been unable to influence the cost of care.

For example, current and precise comparative information about options, prices, and quality of health services is rarely available to the consumers of those health services.

Another example, when nonphysician health care practitioners, such as nurse midwives, have attempted to compete with physicians to deliver care, in many cases, the established health industry has moved aggressively to preserve its monopolistic turf.

In addition, continued expansion of proprietary health care, such as for-profit hospitals, are contributing to escalating health care costs.

Excessively high fees for ancillary medical services raise questions about bill padding.

Consumers must demand a role in health care decisions in order to prevent their interests from being sacrificed to the profitmaking protential of the health care industry. Public policy must provide the opportunity for consumers and their representatives to assert their collective buying power and bargaining power to negotiate with physicians, hospital administrators and insurers for quality care at lower prices.

Knowledgeable, cost conscious consumers can become more prudent buyers of health care, channeling business to those doctors and hospitals who are also cost conscious and efficient.

The Health Care Cost Control Act of 1983, introduced by Representatives Shannon and Mikulski, is a positive progressive step forward to rein in runaway health care costs. By reforming the way health care costs are determined, this legislation aims to make our Nation's health care bill affordable without reducing benefits, restricting eligibility, or limiting access to the health care system.

In establishing a mechanism by which consumers can participate in the determination of hospital rate increases and physician fee schedules, this legislation gives consumers some leverage for controlling health care costs. Through public participation, consumers can be in a position to question fees, the services and procedures those fees are meant to cover, and to discuss fees with physicians and other interested parties in order to arrive at reasonable and equitable rates.

In this way, health care providers can be more responsive to the interests of the health care consumer and patient, whom they have been educated to serve.

Earlier this year, the Congress made a decisive move in the social security legislation when it substituted prospective payment reimbursement for the cost-based reimbursement of the medicare part A payments. H.R. 3261 is a necessary next step to containing health care costs across the board.

Unless all payors are required to participate in a prospective reimbursement plan, the health care system will undergo a massive shifting of costs to private payors. Employers and workers who stand to benefit as taxpayers will inevitably lose out as they pay increasingly higher insurance premiums or more out-of-pocket expenses for medical bills. This legislation provides a comprehensive way of preventing this cost shifting.

Although the league supports this legislation, we believe that it could be strengthened by including language that assures that essential services are not cut to keep within a fee schedule. The quality of care must not be sacrificed to maintain profit margins.

Our fear is that rather than cutting costs by eliminating waste and inefficiency, physicians and hospitals, in a rush to preserve profits, will encourage reductions in full time nursing staff and other hospital personnel who provide essential services. It is vital that the legislation protect against this occurrence.

Mr. Chairman, your subcommittee is to be commended for examining remedies to the problems of health care inflation at a time when Americans are becoming increasingly alarmed about assuring access to health care and controlling its cost. It is a problem which deserves our immediate and continued attention.

Mr. Chairman, I want to thank you for the opportunity to testify and to offer you our assistance in working to improve and enact this vitally needed legislation.

Chairman JACOBS. Thank you, Ms. Warden.

[The prepared statement follows:]

STATEMENT OF BARBARA F. WARDEN, EXECUTIVE DIRECTOR, NATIONAL CONSUMERS LEAGUE

Chairman Jacobs and members of this very important subcommittee, my name is Barbara Warden. I am executive director of the National Consumers League. I want to thank you for giving me an opportunity to testify before the subcommittee on the subject of health care cost containment.

The National Consumers League, founded in 1899, is the oldest consumer organization in America. For the past 84 years, the League has been a leader in advocating improvements in the social and economic conditions in our country, and has repeatedly fought for worker and consumer rights and for effective enforcement of laws that protect and ensure those rights. The League has a profound interest in safety and health concerns, and has been instrumental in achieving child labor restrictions, food and drug safety protections, and occupational safety laws.

At this time in its long history, the League is embarking on a new program dedicated to making our health care system more responsive to the needs of consumers. We are building a network of health care advocates, training them to play a more assertive role in health care decisions and to question the quality of the health services they are buying. The League is currently conducting a program in Philadelphia, where we are training senior volunteers to understand their Medicare health insurance and options in private supplemental health policies. They, in turn, will instruct other individuals in their communities.

This subcommittee has undertaken a most difficult assignment in considering H.R. 3261, the Health Care Cost Control Act of 1983, which the League endorses. Though this legislation provides a constructive approach to addressing one of the most perplexing and difficult problems of our era, escalating health care costs, its enactment will be an uphill struggle. By examining ways to control health care costs, you are challenging the domain of a deeply entrenched, extremely well fi-

nanced, and very influential sector of our economy, the health care industry. It is a formidable task. Earlier Congresses and the executive branch have failed to reach a solution, but the problems must be tackled if Americans are not to be priced out of their health care system.

The direction in which our health care system is heading is alarming, and no evidence suggests that the trend will be reversed absent strong, comprehensive legislation. We face the very real prospect of having a health care system with the most highly skilled and best educated professionals and the most technologically advanced equipment in the world, but one which will benefit fewer and fewer people. Overall, costs of medical services are becoming prohibitive, with costs for even routine services putting a strain on the family budget, and causing insurance premiums to climb steadily upward. Medical costs have risen far faster than the rate of general inflation, increasing by 11 percent in 1982 or nearly three times the increase of the Consumer Price Index. Private health insurance led the pack of medical increases, rising by nearly 16 percent.

Today, millions of individuals and their families do not have access to health care, while millions of others can afford only the most basic health care. Recent statistics showed:

Some seven million Americans below the poverty line have no health insurance, and an estimated 11 million above the poverty line have no coverage.

More than 19 million Americans have inadequate insurance that fails to cover basic hospital bills, doctors' services or medical tests.

About 83 million Americans (40 percent of the population) have no insurance against very large medical bills.

Eleven million newly unemployed workers and their families have exhausted their health care benefits.

Mr. Chairman, we are faced with an unparalleled dilemma. On the one hand, we have a health care system unrivaled in the world, marked by medical breakthroughs and great technological advances, a system which we can point to with some pride; but on the other hand, it is health care system whose ability to deliver services to those most in need will continue to deteriorate, a system which will be pointed to as our national shame.

In many ways, our health care system has been stood on its head. Rather than having consumers as the center around which our health care system revolves, consumers have become the forgotten element in the health care equation. Our health care system is a complex and peculiar service industry of diverse providers—private practitioners, hospital-based or free-standing medical groups, hospital-based or outpatient clinics and emergency rooms, community health centers, health maintenance organizations, nursing homes, and hospice centers—which can dictate the accessibility, cost, and types of services available. Health care is our nation's second largest employer with over six million people employed in the health care field. In 1982, America's national health bill totaled $322 billion, a levy of about $1,400 on every man, woman, and child in our country, constituting about 10 percent of our gross national product. Last year Medicare and Medicaid paid $82.7 billion for health care services for beneficiaries. This year, U.S. companies will pay $77 billion in health insurance premiums for their employees, retirees and dependents, more than those companies will pay our in dividends.

By any measure you use, the health care industry is big business. But it is a business whose structure is unique to our free market economy in that demand is not set by the buyer, but by the very people who supply the services. The present suppliers of health care services are largely unrestrained by the traditional marketplace characteristics of quality comparison, truth in labeling information, price competition, information disclosure, and informed consumer consent. Normally, it is the buyer who decides what service or commodity to purchase, whether it is a hair cut or a lawnmower. In medicine, there is a peculiar relationship between the buyer and the seller. Decisions are made mostly by the seller, i.e., the physician. The physician as a businessperson is one of the few American entrepreneurs who has the power to influence, if not determine, the level of the demand for his or her services.

The doctor has every incentive to make decisions without regard to cost. So do hospitals, since their charges for tests help pay for the expensive equipment used to conduct them. Since hospitals are generally reimbursed on a cost (or in the case of for-profit hospitals, a cost-plus) basis, and doctors are paid based on fee for service, the current system has encouraged more spending. The more hospitals spend, the more they receive the more services doctors perform, the more money they make.

In contrast to the dominant position providers have assumed in our health care system, consumers have been relegated to the role of unenlightened and unassertive, but grateful, fearful, and compliant dependents. Consumers have been cut

adrift from most of the decisionmaking about their own health care. Consumers have been discouraged from inquiring about physician and hospital fees, or about basic services and procedures.

Though health care costs have been identified in surveys as the public's primary health concern, consumers have been unable to influence the cost of care. For example:

Current and precise comparative information about options, prices, and quality of health services is rarely available to the consumers of those health services.

When non-physician health care practitioners, such as nurse midwives, have attempted to compete with physicians to deliver care, in many cases, the established health industry has moved aggressively to preserve its monopolistic turif.

Continued expansion of propreitary health care, such as for-profit hospitals, are contributing to escalating health care costs.

Excessively high fees for ancillary medical services raise questions about bill padding.

Consumers must demand a role in health care decisions in order to prevent their interests from being sacrificed to the profit-making potential of the health care industry. Public policy must provide the oportunity for consumers and their representatives to assert their collective buying power to negotiate with physicians, hospital administrators and insurers for quality care at lower prices. Knowledgeable, cost conscious consumers can become more prudent buyer of health care, channeling business to those doctors and hospitals who are also cost conscious and efficient.

The Health Care Cost Control Act of 1983, H.R. 3261, introduced by Representatives Shannon and Mikulski is a positive, progressive step forward to rein in runaway health care costs. By reforming the way health care costs are determined, this legislation aims to make our nation's health care bill affordable without reducing benefits, restricting eligibility, or limiting access to the health care system. In establishing a mechanism by which consumers can participate in the determination of hospital rate increases and physician fee schedules, this legislation gives consumers some leverage for controlling health care costs. Through public participation, consumers can be in a position to question fees, the services and procedures those fees are meant to cover, and to discuss fees with physicians and other interested parties in order to arrive at reasonable and equitable rates. In this way, health care providers can be more responsive to the interests of the health care consumer, whom they have been educated to serve.

Earlier this year, the Congress made a decisive move in the Social Security legislation when it substituted prospective payment reimbursement for the cost-based reimbursement of the Medicare Part A payments. H.R. 3261 is a necessary next step to containing health care costs across the board. Unless all payors are required to participate in a prospective reimbursement plan, the health care system will undergo a massive shifting of costs to private payors. Employers and workers who stand to benefit as taxpayers will inevitably lose out as they pay increasingly higher insurance premiums or more out-of-pocket expenses for medical bills. This legislation provides a comprehensive way of preventing this cost shifting.

Although the League supports this legislation, we believe that it could be strengthened by including language that assures that essential services are not cut to keep within a fee schedule. The quality of care must not be sacrificed to maintain profit margins.

Our fear is that rather than cutting costs by eliminating waste and inefficiency, physicians and hospitals, in a rush to preserve profits, will make cuts in full time nursing staff and other hospital personnel who provide essential services. It is vital that the legislation protect against this occurrence.

Mr. Chairman, your subcommittee is to be commended for examining remedies to the problems of health care inflation at a time when Americans are becoming increasingly alarmed about assuring access to health care and controlling its cost. It is a problem which deserves our immediate and continued attention.

Mr. Chairman, I want to thank you for the opportunity to testify and to offer you our assistance in working to improve and enact this vitally needed legislation.

Chairman JACOBS. We are very pleased to welcome an old and dear friend to this committee. The last shall be first.

STATEMENT OF RUTH E. KOBELL, LEGISLATIVE ASSISTANT, NATIONAL FARMERS UNION

Ms. KOBELL. Thank you.

I appreciate the opportunity to present the views of the National Farmers Union on what we believe is very important legislation. I am Ruth Kobell, legislative assistant for the National Farmers Union.

We support the enactment of H.R. 3261, the Health Care Cost Control Act of 1983, because we believe it would provide a broad-based approach to controlling escalating health care costs.

In the interest of time, I would ask that my statement be included in the record. And I would like to make a few comments about the issue.

Certainly, a great many arguments have been made this morning as to the need for this program. I want to bring to your attention the special concerns of farm families. It has been said that farmers have to sell wholesale and buy retail and pay the freight both ways. Farmers often have to pay higher costs for the health care they have and try desperately to maintain the structure of health care delivery in their communities.

Farming is still the third most dangerous occupation in this country, following forestry and mining. The first conference to focus on the problems of disabled farmers was sponsored this summer by the University of North Dakota and Purdue University. It was pointed out that a third of all farmers suffer some disability, and so disability and rehabilitation care is particularly important to farm families.

Recently, I attended a conference of farm women in North Dakota and simply asked them to give me some figures as to what they pay for health care costs. A couple not eligible for medicare were paying $300 a month for a hospitalization policy. A couple receiving medicare were paying about $100 a month. When you realize that net farm income in 1982 averaged $8,000 a year per farm family, it takes a large piece of that net income to simply provide some kind of basic health care costs.

Certainly, those farm families who have available to them the health maintenance organizations' services are able to provide a more efficient approach, and I hope that we can look forward to continued support for developing HMO's.

Particularly as you move into the prospective payment of hospital costs under medicare, we appreciate the fact that you wrote in some protection for small rural hospitals. I, too, have considerable concern for the expansion of for-profit hospital chains and the effect that they may ultimately have on the smaller—and sometimes viewed as underutilized—rural hospital.

My brother used to live in a very small town in Montana, and he said that the difference between a housing shortage and a housing surplus in that town was one house. The difference sometimes between a full hospital in an emergency and an underutilized hospital may be several beds, but they are impacted by a cost containment program that is based on a thousand-bed hospital.

We appreciate the fact that small hospitals have a sole community provider provision through which they can be recognized for excessive costs, and we hope that in considering cost containment legislation you will continue to have your staff look at the way these are handled.

I have given your staff a copy of a series of articles on rural health published in the Rocky Mountain News last month which perhaps provides some definitive view of some of the problems we face out there.

We appreciate the opportunity to be here and to present our views, and we look forward to working with you on this issue.

[The prepared statement and attachment follow:]

STATEMENT OF RUTH E. KOBELL, LEGISLATIVE ASSISTANT, NATIONAL FARMERS UNION

SUMMARY

(1) We support enactment of H.R. 3261, the Health Care Cost Control Act of 1983 because we believe it would provide a broad-based approach to controlling escalating health care costs.

(2) We oppose increased cost sharing by Medicare patients. They already pay from ⅓ to ½ of their medical expenses.

(3) Farm families usually have higher health insurance policy costs because they often buy individual familiy policies and have little opportunity for group bargaining.

(4) Farm families and other rural residents must be assured of continued access to health care through maintenance of local hospitals, resident doctors and emergency and other support services.

(5) Health consumers must be represented and involved in health care planning, cost controls, and planning for access to service.

STATEMENT

Mr. Chairman, I am Ruth E. Kobell, Legislative Assistant, National Farmers Union, 600 Maryland Avenue, S.W., Washington, D.C. 20024. I represent the views of the farm families in the bread basket of America who make up the National Farmers Union and who raise an abundance of food and fiber for this nation and people around the world.

Our members have a long history of concern with the cost, quality and accessibility of health care for their families and for other people in rural communities and across the nation. They demonstrate this concern in a broad-based policy statement, most recently adopted by delegates at our National Farmers Union convention in San Diego last March. I am attaching a copy of this statement to my printed remarks.

They also demonstrate this concern by serving on their local hospital boards, the area and state health systems agencies, advisory committees and boards, private community fund-raising efforts. They drive ambulances, take CPR training, and assist local hospital with their volunteer work. It is estimated that they and other families provide more than 80 percent of the care of their disabled family members in their homes, with their own support systems.

Even with all these efforts, we have seen health care costs escalating ever more rapidly and services being more and more limited under the present system of health care delivery. We believe any effective control for containing costs must be broad-based and comprehensive. For that reason, we urge passage of H.R. 3261, The Health Care Cost Control Act of 1983, which was introducted on June 9 by Congressman James M. Shannon and the subject of your hearing today.

Congressman Shannon described it as "a comprehensive plan to contain costs of public and private health programs, while at the same time protecting consumers of health care. This legislation is an essential first step toward achieving the dual goals of bringing federal health expenditures under control and making available affordable health care to those now protected in whole or in party by private insurance."

A Washington Post article recently noted that the nation's medical bill has risen to $322 billion, 10½ precent of the gross national product. This is the highest such share of the GNP in history, according to figures compiled by the Department of Health and Human Services. Costs continue to increase by two or three times the general rate of inflation. The cost of private health insurance rose more than any other medical service last year, nearly 16 percent.

We recognize that the legislation contained in the Social Security bill this year changes the way in which hospitals will be reimbursed for care given Medicare pa-

tients. This demonstrates the concern that Congress holds for the escalating pressures of health care costs to Medicare and other citizens. Beginning October 1, 1983, Medicare will no longer pay hospitals on a cost-plus basis for each service rendered, but will pay a predetermined rate on the patient's diagnosis-related group (DRG). Hospitals can keep any surplus they generate but must absorb any losses. These cannot be passed on to Medicare patients.

At the time of the bill's passage, concern was voiced that without broader attention to health care cost control, there would be a shifting of additional costs for Medicare to other patients. The thrust of this Health Care Cost Containment legislation addresses this concern because it would put limits on the charges on all health care providers to put a brake on the escalation.

We do not believe that additional cost sharing should be heaped upon Medicare patients. There are over 29 million beneficiaries of Medicare. Each year, about one out of every three of these people is hospitalized, or about 870,000 each month. Even with the help of Medicare, experts estimate that older Americans pay from ⅓ to ½ of their medical expenses out of their own pockets, averaging about $1,400 per person. One-half of the households headed by Americans aged 65 and over have incomes below $8,780, and more than ¼ of all elderly households have incomes below $5,000 per year. A retired wage earner receiving Social Security benefits receives an average of $411 per month, a widow averages $380 per month, and couples average $709 per month.

It has often been said that farmers sell their production at wholesale, buy their supplies at retail, and pay the freight both ways. Farm families need to keep basic quality health care available to themselves and their communities. Farming is still the third most dangerous occupation, following mining and forestry. Farmers need to have not only a doctor, ambulance, hospital and other supportive services available, but they also need to be able to pay for them. Farm families have often not been able to avail themselves of group heath care policies and so have had to pay the higher single family premium.

Recently, I attended the Farmers Union Women's Camp in North Dakota and asked the participants to list for me their monthly cost for hospital insurance. We did not define the coverage provided by the policies, so the figures are not exactly comparative, but I was surprised to learn that health care costs Farmers Union families in North Dakota everywhere from $300 a month for a couple who are not eligible for Medicare down to less than $100 a month for two people in addition to their Medicare coverage.

I found that some people had individual policies, and some had group policies through their credit union, their cooperative, or their local bank, where they authorized the bank to deduct their premium from their checking account.

One of the benefits extended to patrons by the Farmers Union Milk Marketing Cooperative in Wisconsin has been the availability of a group health policy which helps cut costs and expand coverage. A number of these families are able to belong to health maintenance organizations (HMOs), and one family's dues was quoted at $158 a month for family coverage which included, of course, all doctors' visits, clinic work and hospitalization.

In 1982, the average net income per farm in the United States was $8,000 a year. Just providing a health care policy for family protection takes a major chunk out of such farm income. We have learned that some farm families, bordering on bankruptcy, find it impossible to continue health insurance and thus expose themselves and their families to limited care and catastrophic emergency costs.

We believe that any discussion of cost containment must assume continued availability and access to quality health care. I have some concern about the effect of the rapidly growing for-profit hospital chains and nursing home chains with their mandate to show a quarterly earning for their stockholders will have on operation of what some may view as marginal efficiency of some rural hospitals. We are glad Congress recognized that some small hospitals may have wide utilization swings and provided for extra consideration through the sole community provider provision for those hospitals meeting special criteria. We hope you will continue to consider such protection in developing this or other cost containment legislation.

On the other hand, I expect many small hospitals are in need of help in management practices, training, supply purchases, and malpractice insurance. The federal investment of funds under the Hill-Burton program in building rural hospitals considerably expanded the infrastructure that is presently in place. Many communities also benefited from the resources available through Farmers Home Administration in the purchae of ambulance equipment. Many other communities have used their own community resources to make the capital investment, only to find that tightening budget pressures make it increasingly difficult to maintain adequate quality of

service. Perhaps there should be the kind of circuit rider technical assistance that we used to talk about in other rural development programs. Some hospitals are banding together in voluntary associations to provide themselves with these services.

In August 1983, the Rocky Mountain News, a Denver daily newspaper, reported on a five-month investigation of rural health care in Colorado. I have provided your staff with a copy of the seven articles which appeared as a result of that investigation by a medical reporter and assistant editor who were familiar with rural health issues. During its investigation, it asked four hospital administrators to review inspection reports by the state health department of 19 rural hospitals. There are 100 hospitals in Colorado, of which 50 are in rural areas. The investigation showed that care ranged from excellent to negligent and that quality of care related to isolation of physicians, failure in state inspection systems, and sometimes in the inability of a community to change situations that were recognized as questionable.

The Rocky Mountain News article pointed out that many hospitals, physicians, and ambulance companies in rural Colorado offer good care. But Colorado ranks forty-ninth nationally in funding for emergency medical services, such as ambulance services and training of emergency medical technicians (EMTs) who are the first to treat accident victims. The lack of state standards for ambulances results in treatment that ranges from excellent to patients literally being thrown in the back of a truck.

At least three people died last winter in a southern Colorado county after the county shut down the ambulance service, rather than spending another $16,000 to keep it operating. Only one small ambulance company serves a 60-mile stretch of Interstate 70 from the outskirts of Denver to the Eisenhower Tunnel, traveled by 15,000 vehicles a day. Each year, about 475 people are injured in traffic accidents along that route.

As there is greater pressure on controlling health care costs and additional emphasis on efficiency and cost effectiveness, I urge that we keep that always in the context of the right of quality and availability of health care for all our people.

I remember the pressure to consolidate rural schools on the theory that they could provide higher quality instruction at lower cost. Twenty years later, the analysis proved that the cost had increased and the quality had not been improved over the smaller local schools.

I believe the Health Care Cost Control Act moves in important ways including provisions that would control the growth of out-patient and physician costs. The bill establishes a maximum permissible rate of increase for physician fees, which is designed to allow physicians to recoup increased expenses due to inflation in the cost of overhead and goods and services. Physicians could not charge, in the aggregate, more than the maximum fee established by the bill. In other words, assignment would be mandatory. Although doctors are responsible for prescribing treatment, both in and out of the hospital, their fee schedule is often not discussed until a bill for their services arrives, and consumers, particularly in rural areas, have little opportunity for comparative shopping or economic judgments in terms of needed professional services.

We have been told that consumers must take more responsibility for their own health care, including changes in lifestyle, such as smoking, drinking and weight reduction. We are reminded that the single most important step taken in increased health and safety has been the 55-mile speed limit which has reduced both accidents and deaths.

I believe that an important part of H.R. 3261 is the involvement of health care consumers, along with providers and state and federal governments in the establishment of maximum fee schedules for physician and related services. Although the bill provides that states operate their own cost containment programs, I believe it will be important to assure minimum federal standards. We all live in the same great nation. We all should be assured of adequate health care, whether we're driving across the plains of Wyoming or vacationing in the center of New York City, whether we live in Mississippi or Wisconsin.

Health maintenance organizations are a prime example of organizations which must focus on delivery of quality health care to their members within strict cost guidelines. It will be important to protect their viability and to provide consumers an opportunity to expand this form of health care service.

Our investment in science and research has provided techniques and information that can make our lives happier and healthier but only if we can have access to the care.

THE 1983 POLICY OF NATIONAL FARMERS UNION

ARTICLE IX—HUMAN RESOURCES AND THE FAMILY FARM

Former Vice President Hubert H. Humphrey noted that the ultimate moral test of any government is the manner in which it treats three groups of its citizens: First, those who are in the dawn of life, our children; second, those who are in the shadows of life, our sick, our needy, our handicapped; and third, those in the twilight of life, our elderly.

Development of social programs financed and administered by the federal government over the past fifty years supported the concept that citizens of the United States should be assured minimum availability of food, housing, health care, education, and job training, regardless of where they lived. A broad range of social programs were enacted on the federal level because many state and local governments were not providing the needed services at adequate levels.

President Reagan has called for consolidating many of these categorical programs into four block grants in the areas of education, social services, health, and community development, with an initial request for substantial cuts in funding and broad discretion on which program services will be continued for local citizens.

We believe this is an implicit redefinition of the role of the federal government and will provide the vehicle for further program cuts and their ultimate destruction.

We believe a national rural policy should recognize the difficulty and greater cost of providing necessary health, education, and social services.

We recommend that USDA maintain its traditional role as the lead agency in rural development.

A. Health

National Farmers Union reaffirms its long-standing commitment to national, comprehensive, mandatory, universal prepaid health insurance. We further urge prompt Congressional action to control the sky rocketing costs of health care.

1. Health planning

We support continuation of the Health Planning and Resource Development Act of 1974 which provides opportunity for local citizens, health care professionals, and government representatives to exert some control on health care facilities, services and manpower costs, and improves the public's knowledge of health care issues.

We urge farm people and other rural consumers to participate in local and state health planning and review.

2. Alternative health care

We urge creation and support of alternative health care delivery systems that recognize the special nature of rural communities. These can include health care clinic staffed by nurse practitioners and physician assistants, improved emergency transportation facilities, training of rural people to provide health services in their own communities, make available in-home health care services for the rural handicapped for more than an 8-hour day, among others.

Where state law prohibits the use of physician assistants and nurse practitioners in free-standing rural clinics, Farmers Union should provide leadership in urging state legislatures to change the statutes.

An amendment to the recently enacted Orphan Drug Law (P.L. 97-414) corrects the barrier to the Department of Health and Human Services from repaying Farmers Home Administration (FmHA) community facility loans which made possible the financing of rural clinic facilities. FmHA returned unexpected community facility funds to the Treasury in 1982.

We urge FmHA to remind its local officers and rural health networks of the availability of these resources for the improvement of rural health care.

3. Health maintenance organizations

We recommend that Farmers Union members actively promote establishment of non-profit, member-controlled, Health Maintenance Organizations in rural areas as a means of providing quality care at reasonable cost. We urge state organizations and National Farmers Union staff to give support to such efforts.

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4. Nursing home standards

We support national health care services for elderly people so they remain in their own homes as long as possible. We support nursing home standards and enforcement of standards so patients receive quality care. We support development of a "Patients Bill of Rights."

5. National Health Service Corps

The National Health Service Corps (NHSC) has provided medical training for many young men and women who could not otherwise have secured their health care training. It has also made their services available to rural and other medically underserved areas and encouraged many of them to stay and establish private practice, thus strengthening and expanding rural health care delivery.

No funds have been provided for NHSC first-year scholarships since 1982. We urge that funds be provided in the fiscal year 1983 appropriations legislation to support enrollment and training of new recruits to this valuable program.

6. Community health centers

Many federally financed community health centers have lost support because of budget cuts and block grants. We urge restoration of this support to develop and continue such effective and efficient local health care delivery systems.

We urge local Farmers Union and other community groups to consider organizing community health centers as local health care cooperatives, which could be eligible for financing from the National Consumer Cooperative Bank.

7. Medically underserved area redesignation

The Bureau of Health Care Delivery and Assistance (formerly Community Health Services) of the Department of Health and Human Services deleted late in 1982 some 1300 medically underserved areas from current listing. Such designation is required for participation in the rural health clinic program and other assistance.

Medicare costs have been increasing rapidly, not because of excessive demand for services, but because health care costs have been increasing more than twice as fast as the general inflation rate. When hospitals were threatened with the Hospital Containment Bill during the Carter Administration, they limited that rapid increase. Without the threat of legislative action, costs have returned their spiral.

The Department of Health and Human Services was directed by Congress to submit a recommendation for a Medicare prospective payment system to hospitals. It has recently done so.

We are concerned that such efforts to cut costs should not result in increased costs for older users, either through cutting back on coverage or increasing coinsurance, or deductibles, or shifting costs to privately insured patients.

Such cost-cutting efforts must recognize the special needs of small rural hospitals so they can be in a position to continue to extend services to their Medicare clients.

Chairman JACOBS. Ms. Kobell, we appreciate your contribution to the record. Just a cursory examination, I might say, of the various times brings you in second for the day on the conciseness route. So in honor of one of our earlier witnesses, you will receive by mail a Kennedy half, and the first prize winner will receive two Kennedy halfs, as Susan B. Anthony dollars are getting scarce. I used to give those out.

Mr. Shannon.

Mr. SHANNON. Thank you, Mr. Chairman.

I just want to thank the both of you for testifying today. I really think it is important, and I think both of your organizations serve a very useful purpose in this issue and in health care issues generally. It is important that this issue be debated not as a struggle among various interests in Washington or various interests within the health care professions, but be discussed in terms of the people who are ultimately going to benefit from it and the people who need greater access to quality health care.

I think the fact that you are here representing the organizations which you represent really contributes an awful lot to the discussion at this very important stage. And I just want to thank you for that and tell you that we really do look forward to working with you in building a national coalition to move health care policy in this direction.

Ms. KOBELL. Thank you very much.

Ms. WARDEN. Thank you.

Chairman JACOBS. Mrs. Warden and Ms. Kobell, we express our appreciation to you for your contributions to these proceedings.

In the words of General MacArthur in the surrender at Japan, these proceedings are closed.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

AMERICAN COLLEGE OF RADIOLOGY,
Chevy Chase, Md., September 28, 1983.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR CONGRESSMAN JACOBS: The following comments regarding portions of H.R. 3261 are offered on behalf of the 15,000 members of the American College of Radiology with their request that these be made part of the record of your hearing of September 28.

The members of the College are physicians and other radiation scientists who provide medical imaging and cancer therapy services to Americans using ionizing and other forms of radiation. They and their practices would be affected by enactment of H.R. 3261 as proposed.

Radiologists are fully aware of the need for public action to restrain the current increases in health care costs incurred by public sector programs. Our comments on Public Law 97-248 (TEFRA) and Public Law 98-21 (Social Security reform) reflect our concerns. Within the limits of our own resources and the restraints of anti-trust laws, the College has developed programs for its members to emphasize cost-consciousness and quality assurance.

Thus, we appreciate the intentions of the sponsors of H.R. 3261 and of this subcommittee without concurring in the specific programs and solutions proffered therein.

Several citations in the bill relate specifically to radiology. We limit our comments to those.

In paragraph (c) of section 2142, we find that the state plan is to develop ". . . schedules of maximum payment for outpatient services (other than diagnostic laboratory and X-ray services) and for physicians' services furnished to inpatients of hospitals or other medical institutions to be developed only after providing opportunity for negotiations described in paragraph (2)."

Then at paragraph (d) of that section, we are particularly distressed by the segregation of our services, "X-ray services" from the bulk of hospital and physician activities. No reason is given for such segregation.

It has been the position of this organization since the growth of the specialty of diagnostic and therapeutic radiology that radiologists are, in fact and intent, physicians using ionizing and other radiation as other physicians might use stethoscopes or scalpels to diagnose and treat disease conditions. Radiologists in their own offices incur operating expenses and bill patients fees intended to cover both their professional involvement and their operating costs. The fees of radiologists practicing in hospitals are intended to cover only professional services, since the hospital charges cover operating costs. There is no discernible need for separate treatment for radiology.

Indeed, when we look to section 2161(1) we find a definition which does not define. "(1) The term 'diagnostic X-ray and laboratory services' has the meaning given such term by the secretary (of HHS), but does not include such services furnished to inpatients of a hospital or other medical institution." Upon which, we are more baffled than before. Heretofore, the nature of a medical service did not depend upon whether the patient was erect or supine while receiving it.

As the phrase is used in section 2142(d)(1) and again in section 2162(1) the modifier "diagnostic" applies either to "laboratory" or else to "laboratory and X-ray services" and we are reluctant to presume one or the other. Similarly, we are reluctant to assume that repeated use of "X-ray" indicates no intent to recognize or segregate diagnostic procedures involving radioisotopes, ultrasound or magnetic resonance. If the purpose was to distinguish between the services of radiologists and other physicians, the language is inadequate. If the intent was otherwise, we fail to follow.

Still further regarding our confusion, the common usage of "provider" in existing Medicare law and regulations is limited to hospitals and other institutions recognized under Part A of the program. If section 2142(d) applies only to institutions, we still think it unnecessary. But we cannot draw that conclusion after reading section 2161(1).

However it is meant, we object most strenuously to a prejudicial and ambiguous legislative mandate for separate treatment of radiology.

Sincerely,

OTHA W. LINTON,
Director of Governmental Relations.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

SUMMARY

We strongly oppose, H.R. 3261, the "Health Care Cost Containment Act of 1983," imposing all payors revenue controls on hospitals. This legislation does nothing to address demand for and utilization of health care services and would result in lower quality or rationing of hospital services.

This legislation would also lock in existing inequities in hospital reimbursement by rewarding high cost hospitals and penalizing those hospitals with lower base year costs. Current state mandatory rate setting programs with Medicare waivers in New York, Massachusetts and New Jersey have already cost hospitals in other states of millions of dollars by reducing DRG rates to permit the exemption for substantially higher rates in those waivered states.

We support a ceiling on tax-free employer purchased health benefits designed to encourage the offering of multiple insurance plans; benefit redesign to require reasonable cost sharing by Medicare beneficiaries during the first 30 or 60 days of a hospital stay up to a catastrophic level, in order to encourage restraint in utilization; and a voluntary Medicare private insurance option.

These changes, in conjunction with a Medicare hospital prospective payment system will help achieve a rational health policy, dealing effectively with the underlying problems with our current system and alleviating the need for future, drastic government regulation of our health care delivery system.

STATEMENT

The Federation of American Hospitals is the national association of investor-owned hospitals and hospital management companies, representing 1,045 hospitals with over 120,000 beds in the U.S. alone. Our member hospital management companies also manage under contract more than 300 hospitals owned by others. Investor-owned hospitals in the United States represent more than 20 percent of all non-government hospitals. In many communities, investor-owned facilities represent the only hospital serving the population.

We appreciate this opportunity to present our views on H.R. 3261 "The Health Care Cost Control Act of 1983." These hearings come at a very important time. Congress has just enacted the most significant change in Medicare hospital reimbursement since the inception of the Medicare program by establishing a prospective payment system. Although prospective payment is an important first step, it alone will not solve the problem of health care inflation, and the impending insolvency of the Medicare Trust Fund.

INCREASED DEMAND

Because the proportion of the population over 65 will increase markedly over the next decade, the utilization of health care services per capita is expected to increase dramatically. Medicare expenditures, even after being adjusted for inflation, are expected to increase by 60 percent over the next five years.

Among the major contributing factors to hospital cost increases are admissions and intensity. The cost of treating over age 65 patients generally is more than two times the cost of treating patients under age 65 in hospitals. The following chart illustrates the admission intensity trend:

	Percentage increase in admissions				
	1978	1979	1980	1981	1982
Under age 65	1.0	1.7	1.5	0.0	−1.6
Age 65 and older	4.9	5.3	6.7	3.0	4.1

The intensity area also includes technological advances which save and prolong lives and are costly. There are many social, ethical and economic questions which can be raised in this area, but an aging society requires more intensive health care.

During the past twelve months admissions of over age 65 patients rose more than four percent while the rate of under age 65 admissions declined. Demand is the single most serious aspect of hospital cost increases and until demand is addressed, there will be no solution to health care inflation.

REGULATION

Proponents of a broad regulatory approach such as H.R. 3261, "The Health Care Cost Containment Act of 1983," support Federal or State hospital rate contol programs covering all payors as the answer to increasing health care expenditures. Besides failing to deal with the central problem of demand, or too much utilization, an all-payors system would make things worse. Here is a short list of adverse side effects:

All payors, also known as state rate setting, would stifle delivery system innovation, the best hope for greater cost effectiveness.

There is no price competition.

Bureaucratic preferences or political clout would determine who gets capital, not management performance. Decisionmaking would become politicized and centralized.

The consumer is the ghost at the banquet; collectively, they have under state rate setting no say in how or where resources are allocated.

Future patients get shortchanged because the political pressure for "savings" forces hospitals to strip maintenance and depreciation reserves to cover operating expenses. This causes them to run in the red and eventually turn to taxpayers for a bailout.

The evidence is strong that rate setting does not improve hospital efficiency. A review of existing state rate controls indicates little difference in expenditure growth on a per capita basis between the seven states with controls and all other states. 1981 per capita hospital costs rose 14.4 percent in rate control states compared to 17.5 percent in all other states—no significant difference in 1981. Maryland also incurred per capita increases of 16.1 percent.

Hospital care is more expensive in states with mandatory rate setting programs. In 1981, per capita hospital expenditures for the seven states with mandatory programs were $426 versus $387 for non-mandatory states.

Analysis of rate setting programs in the aggregate is quite misleading because individual state programs differ greatly both in design and effectiveness.

The most up-to-date regression based analysis of the effects of individual state rate setting programs shows no statistically significant savings in hospital spending per capita except in New York and New Jersey. Regardless of the measure used (hospital expenditures per day, per admission, or per capita), the Maryland, Massachusetts, and Washington programs show no signs of having been effective. (Michael A. Morrisey, Frank A. Sloan, Samuel A. Mitchell, "State Rate Setting: An Analysis of Some Unresolved Issues," Health Affairs, Vol. 2, No. 2, Summer 1983, Hope Foundation, Millwood, Virginia.)

The two states that did show significant savings from rate setting—New York and New Jersey—by no coincidence have enormous unmet needs for capital to renovate, replace, and modernize hospitals. New York's unmet capital need in the eighties is projected at $13 billion, New Jersey's at $4.9 billion. Together, these two states alone account for a third of the total national need. (Harold M. Ting and John D. Valiante, "Future Capital Needs of Community Hospitals," Health Affairs, Vol. 1, No. 3, Summer 1982, Hope Foundation, Millwood, Virginia.)

The distribution of Medicare payments among states and the allocation of hospital resources will be strongly influenced by the number of state rate setting systems which seek exemptions from the new Medicare DRG rates. The New York, Massachussetts, and New Jersey waivers, grandfathered by the legislation establishing Medicare DRG rates, have already cost hospitals in most other states hundreds of

millions of dollars by reducing DRG rates to permit the exemption for substantially higher rates in those waivered states. When those waivers expire and those states apply for renewal, there will be a political battle in which hospitals in non-waiver states oppose further waivers on the ground that the law prohibits Medicare paying more than it would under the DRG system and that those additional payments should be used to increase DRG rates for all hospitals. Furthermore, the system proposed in H.R. 3261 locks in these existing inequities allowing higher payments to higher cost hospitals by protecting their historically higher base. Such a system penalizes more efficient, lower cost institutions.

Despite all its drawbacks, many commercial insurers and businesses support state rate setting because in their view it would "eliminate" something called a cost shift. A cost shift occurs when hospitals charge some patients more for the same service than they do others. Typically, people who pay hospital bills themselves or are insured by either a commercial insurance company or by an employer directly, pay more for the same service than Medicare and Medicaid beneficiaries. Simply put, through the cost shift, private patients subsidize public program beneficiaries.

People who promote the idea that state rate setting should be adoped to eliminate the cost shift, fail to understand that it is a hidden subsidy and its elimination is a false hope unless there is a commensurate cutback in services.

A MARKET STRATEGY

If rate controls are not the answer, what is? The first step is incentives reform to encourage more judicious use of health services especially hospitals. The large body of studies examining the cause of health care expenditure growth all point to the same conclusion: the problem is not inefficiency but utilization—patients, freed from the burden of payment, demand more; and physicians and hospitals, unrestrained by cost-based reimbursement, provide more.

Our present system of health care financing has desensitized providers and consumers to the true cost of health care through the extensive use of first dollar coverage and low copayment rates. The situation has been aggravated by cost reimbursement which encourages excessive spending. The result is intense competition but little price competition.

Restoring cost consciousness to providers and consumers is intrinsic to any solution to rising health costs. Without cost awareness, demand for health services is infinite. That is why we urge you to enact solutions which address the demand side of the problem.

This Administration, like others before it, recognized that cost reimbursement has fueled health expenditure increases and needed to be replaced. Congress agreed and recently enacted a system which turns around the incentives in order to reward management efficiency and restrain utilization. We were supportive of the Medicare DRG pricing which became effective on October 1. However, that one long overdue change will not solve the health cost problem. We urge you to accelerate efforts to bring marketplace competition and restraints on utilization to the system by recommending the following legislative proposals:

(1) Benefit redesign to reduce the Medicare deductible and require reasonable cost sharing by Medicare beneficiaries during the first 30 days to 60 days of a hospital stay in order to encourage restraint in utilization; (2) A voluntary Medicare private insurance option; and (3) A ceiling on tax-free employer purchased health benefits, designed to encourage the offering of cost effective insurance plans.

These three changes would address the underlying problems in the current system and would alleviate the need for arbitrary cuts in the Medicare program. Enactment of a ceiling on tax-free health benefits and passage of Medicare benefit redesign with restructing of cost sharing would also produce immediate budget savings.

COST SHARING

The Congressional Budget Office has estimated that ten percent cost sharing from the second day through the 30th day would save over one billion dollars in the first year.

More important than the direct savings from sharing costs is the impact that consumer participation would have to deter excessive utilization.

A large body of economic analysis strongly supports the conclusion that financial incentives have a significant impact on utilization. Utilization goes down as cost sharing goes up. Here is a typical finding: ". . . when compared with full coverage, a 25 percent copayment reduces utilization and expenditures by 20 percent."

(Charles E. Phelps, "Health Care Costs, The Consequences of Increased Cost Sharing," Rand Corporation, Santa Monica, California, November 1982.)

Congress, upon enactment of Medicare and Medicaid eighteen years ago and until quite recently, perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision, combined with a cost based reimbursement mechanism which rewards spending and penalizes efficiency, triggered the demand-pull inflation contributing to the inflation in the health care expenditures. The recently enacted Medicare prospective pricing system is a long overdue step to correct the disincentives of that federal program.

The hospital industry has simultaneously been hit with severe cost-push inflationary pressures for the past ten years. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel, and malpractice insurance; rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; increased capital cost; and increased cost of compliance with government regulations.

Many industries have faced similar cost-push inflation pressures, but none have experienced simultaneously the increased demand for services similar to that triggered with enactment of the Medicare and Medicaid programs using inflationary cost based retroactive reimbursement payments for hospital services.

Even without general inflation, federal and state health expenditures will still grow faster than tax revenues. For example, had there been no inflation over the period from 1977 through 1980, health expenditures would still have grown 14 percent in real terms. Of this amount, about 37 percent would have been due to population growth and 63 percent due to higher utilization per capita.

Since inflation can be dealt with effectively only by appropriate fiscal and monetary policy, health policy—to have the maximum beneficial impact—should focus on the next most important problem—utilization.

The decisions regarding health policy boil down to who should benefit, who should choose, and on what basis the choices should be made. Ideally, the beneficiaries should be both the individual patient and society as a whole. The choice as to the use of health care services should be in the hands of patients and their physicians. And, the basis of choice should be a combination of the best health interests of patients and society's interest that the extra value provided by extra services equals or exceeds the extra cost.

The Federation of American Hospitals thinks that a ceiling on tax-free premium contributions, a uniform employer contribution, and a Medicare voucher system would best strike the right balance between the patient's interest in getting good health care and society's interest that the value of health care benefits exceeds their associated costs.

TAX POLICY

Current tax policies devised to stimulate certain behavior often prevent the efficient delivery of quality health care. Financing of health care through income exclusions and deductions often results in apparent misallocation of health resources, while other Internal Revenue Code provisions and regulations prevent arrangements leading to more efficient use of those resources.

Many view the exclusion from employees' income of the employer contribution for employees' health insurance as a major factor in rising health care expenditures. The "Health Cost Containment Tax Act of 1983," H.R. 2574, introduced by Representative Conable, deals directly with the employer contribution issue and focuses on tax laws as a potential catalyst for health care system reform. Current tax subsidies, over $25 billion in value, fuel the demand for insurance, utilization, and unrestrained spending in the health field.

EMPLOYER CONTRIBUTION EXCLUSION

Presently, under Section 106 of the Internal Revenue Code, amounts contributed by employers for employees' health insurance are not included in the employee's income. This amount also is not included in the amount of the employee's pay which is subject to Social Security taxes. Consequently, employees have a great financial incentive to bargain for more costly, broad, employer financed health benefit packages. Since there is no limit on the amount of the exclusion, neither side—labor nor management—has any financial incentive to reduce health benefits nor provide less than first dollar coverage. Employees are not encouraged to seek benefit packages more specifically tailored to meet their health care needs, especially in

light of the prevalence of group health coverage. Such broad coverage stimulates more frequent utilization of health care services and drives up health care expenditures. It effectively eliminates any cost consciousness on the part of consumers of health care.

Enactment of a ceiling on the employer exclusion would cause many employers to voluntarily offer multiple health plans including a low cost option.

Eliminating the open ended employer contribution while encouraging equal contributions to all employee health insurance plans will stimulate competition among health plans and providers. Also, consumers of health care must have some financial stake in the system through some cost sharing of premiums and copayment of incurred costs in order to bring some market-oriented restraint into decisions about utilization and choice of plans. Higher premium and delivery costs should be borne by the party selecting the plan or provider.

This tax subsidy is estimated by the Congressional Budget Office to exceed $25 billion as of 1983. By comparison, the federal government's share of projected Medicaid spending is only $21 billion. This open ended subsidy is ethically objectionable as well as bad policy.

As the Ethics Commission noted, "The employer exclusion provision gives a larger subsidy to those with a smaller need for financial protection an exacerbates the tendency of lower income people to be less well insured than those with higher incomes." The Commission goes on to say that "this pattern of care is difficult to justify from an ethical standpoint. There seems to be little reason for such government assistance to middle and upper income individuals, most of whom could take financial responsibility for their own care . . . without undue hardship." We heartily endorse this position and believe that on fairness grounds alone the tax cap should be applied forthwith.

CONSUMER CHOICE FOR MEDICARE BENEFICIARIES: THE VOUCHER OPTION

Medicare pays for about 16 percent of total personal health expenditures. Thus, any discussion about health system reform or consumer choice legislation is incomplete, and possibly irrelevant, without the inclusion of Medicare-Medicaid reforms.

A consumer choice approach allows consumers to shape the health care system according to *their own* preferences as directly revealed in *their* purchase decisions. Government, which can never know consumer preferences as well as consumers themselves, is no longer necessary as an intervening agent. This pro-competition strategy treats health care like other industries such as housing and food—basic necessities of life which are essentially unregulated except for government programs to help the aged and disadvantaged.

A VOUCHER SYSTEM

We support a Medicare voucher option as the financing vehicle for offering consumer choice to Medicare beneficiaries. A federal payment or voucher would, at the beneficiary's option, be used in the purchase of private health plans (traditional insurance or alternative health systems).

The initial voucher amount should be the average per capita expenditure for Medicare beneficiaries adjusted for age, sex, area and health status.

A voucher approach would in effect be a national experiment in consumer choice. The aged population would decide whether private plans are preferable to a government run system. A Medicare beneficiary would be entitled to have an annual election among qualified health plans or the existing Medicare program. If not satisfied, the beneficiary could choose another plan the following year. States could elect to participate in such a system for Medicaid eligibles as the system progressed.

Although the voucher system is new to health care financing, the basic idea is very familiar to the public. Dollar bills are vouchers. The only difference between a thousand dollar bill and a thousand dollar health insurance voucher is that the money can be exchanged for anything but the voucher only for health insurance.

BENEFICIARY RIGHTS

The consumer choice approach for Medicare-Medicaid patients would produce major changes in the access and influence of the aged and poor in the health marketplace. By arming these patients with vouchers and private insurance or membership in health plans, the proposal will change the attitude of health providers toward these patients. Second class medicine in America is simply an economic term meaning patients for whom reduced payment and increased regulation are imposed on providers by government. The problem of physicians refusing to take Medi-

care assignment or refusing to see Medicaid patients and the "dumping" of Medicaid patients in public hospitals are the direct result of inadequate government reimbursement.

Under a voucher system these patients would be viewed as equal to all other privately insured consumers, increasing their access to quality health care and their influence over they system.

BUDGET IMPACT

From the government's perspective a voucher system means fixed premium payments in lieu of open-ended reimbursement. This should not only make government spending more predictable, but also it will reduce administrative costs. Also, the voucher system would help assure that government health care budgets provide beneficiaries with the best health care possible for the dollar—much better than what they would receive under the status quo. This would happen because use of vouchers encourages innovation in health care delivery—the best hope for better health care at less cost—and forces providers to consider the patient's economic as well as health interests.

PROVIDER IMPACT

A voucher system would impact health providers in several ways. Government regulation and disputes over reimbursement rules would be replaced by health plan negotiations for fixed payment rates. The prices of health providers would become more visible and subject to consumer pressure through their choice of health plans. Providers would be more accountable to the public and would have to justify pricing practices to consumers who would be sharing part of the costs involved in their care.

IMPACT ON INSURANCE INDUSTRY AND HEALTH PLANS

The insurance industry and health plans would be challenged to market private plans to the large segment of the population now covered by government. Innovative benefit packages would be designed to compete with the existing Medicare-Medicaid benefits. Outpatient drugs, home health care, unlimited hospitalization, and nursing home care are four examples of benefits which Medicare does not adequately cover for senior citizens. A plan which adds this kind of coverage might be more attractive to a beneficiary than existing Medicare coverage plus out-of-pocket payment for supplemental insurance.

CONCLUSION

The Health Care Cost Containment Act of 1983 is a regulatory measure which relies on controlling the supply and providers of health services to contain costs. It is true that total costs can be contained by postponing services. The certificate of need regulations of the Federal Health Planning Act have postponed capital expenditures, for example, but they have done nothing to curtail the demand for new services. Rate controls have been enacted by about six states but have only significantly contained costs in New York where arbitrary controls have postponed needed capital spending. Finally, the ultimate regulation of supply in Great Britain and Canada has produced such long waiting lists for health services that many citizens die before reaching the top of the list for treatment.

These supply control techniques cannot work because patients and physicians believe they are entitled to an open-ended amount of care paid for by some other party.

Demand side reforms address that very point by removing or limiting open ended subsidies, such as the exclusion from taxable income of all employer purchased health insurance. By stimulating price consciousness through tax reforms, cost sharing, and preferred provider contracting, demand side revisions use market forces to negotiate prices and penalize excessive capital spending.

We do not support the regulatory strategy of H.R. 3261 because it fails to address the critical issue of demand. We believe it is time to limit federal tax subsidies for health insurance, impose reasonable cost sharing for federally financed services, and use the marketplace as a more effective regulator than government of health care costs.

Prospective payment is a long overdue Medicare reform but it will not solve the problem of unrestrained demand for health services. If everyone is to be guaranteed unlimited health services, then cost control systems cannot solve the government's

budgetary problems. If some limits on the amount of government financed health services are acceptable, then the question is how to allocate limited tax dollars.

We urge Congress to address broader health policy issues by bringing marketplace competition to the restraints on utilization of our health care system by enacting the following legislative proposals: a ceiling on tax-free employer purchased health benefits designed to encourage the offering of multiple insurance plans; benefit redesign to require reasonable cost sharing by Medicare beneficiaries during the first 30 or 60 days of a hospital stay up to a catastrophic level, in order to encourage restraint in utilization; and a voluntary Medicare private insurance option.

These changes, in conjunction with a Medicare hospital prospective payment system, will help achieve a rational health policy, dealing effectively with the underlying problems with our current system and alleviating the need for future drastic government regulation of our health care delivery system.

STATEMENT OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Group Health Association of America (GHAA) represents over 120 prepaid group practice plans, a majority of the group and staff model health maintenance organizations (HMO's) in the country. GHAA's member plans serve in excess of 9 million enrollees, 80 percent of the total national HMO enrollment.

We are pleased to have the opportunity to comment on H.R. 3261, the Health Care Cost Control Act of 1983. We, of course, share the widespread concern about the rapidly rising cost of health care, and we commend the bill's sponsors, Congressman Shannon and Congresswoman Mikulski, for their efforts to propose a comprehensive solution to a set of very difficult problems.

While we have never considered ourselves either the sole or the primary answer to health care cost inflation, HMO's have demonstrated that they have a successful system for the efficient delivery of high quality care which has a positive impact on the communities in which they have become well-established. In the development of legislation such as H.R. 3261, which seeks to control costs and promote the more efficient use of resources in the health care marketplace as a whole, our greatest concern is that mechanisms crafted for the predominant fee-for-service sector not inhibit the achievements and potential of HMO's and other alternative delivery systems. While there are several sections of H.R. 3261 which specifically apply to HMO's, the measure does not fully recognize the operating characteristics of HMO's and the difficulties which the broader program might create for them.

As competing carrier's premiums have grown dramatically, HMO's have become increasingly attractive and their success in containing costs has become more and more apparent. Not only have HMO premium increases been consistently lower than their competitors, but in a fairly recent development, HMO premiums are often lower in absolute terms than those of other carriers despite the more comprehensive HMO benefits.

In fact, the comprehensive benefit packages offered by HMO's are fundamental to their operating efficiencies. By organizing a full range of inpatient and outpatient services within a single delivery system, HMO's create incentives for the cost effective and appropriate use of health care resources without sacrificing quality. Basic to our system is improved access to care, without the economic barriers to early treatment which are found in the fee-for-service sector. Also a hallmark of HMO's are practice patterns resulting in hospital utilization rates significantly lower than comparable fee-for-service utilization.

The health care delivery system of the staff and group model HMO's represented by GHAA relies on physicians who are either salaried members of the staff of the HMO or who are members of a group of physicians under contract to the HMO for the predominant part of the group's practice. Such an HMO may also enter into contracts on a capitation, fee-for-service or other basis with physicians and other providers for specialty care. All health care services provided to the HMO's members are coordinated within the plan's system and subject to its practice patterns, utilization review and quality control mechanisms.

Differences between the modes of practice in HMO's and in the fee-for-service sector are particularly noticeable in the use of hospital services. It is for this reason that HMO's in New Jersey have had difficulties with the state's all payor system based upon diagnosis related groups (DRGs).

There, HMO's and other providers must pay rates based upon DRGs reflecting average community patterns of providing health care services. Where the usual length of stay of HMO members is shorter than the community average, where the HMO performs pre-admission diagnostic testing in its own outpatient facilities that would otherwise be performed in a hospital, and where HMO patterns of practice

otherwise differ from those in the community, the HMO must through the DRG rate pay for services not used. The unfortunate result is that while new incentives may promote greater efficiency in the health care community at large, HMO disciplines are weakened. In recognition of this negative impact on HMO's, the program of prospective payments for Medicare inpatient hospital services enacted this spring in the Social Security Reform Amendments of 1983 (P.L. 98-21) included among the criteria for approval of waivers for state all payor systems a requirement that HMO's must not be precluded from negotiating their own rates with hospitals.

The need for this flexibility is even clearer upon a closer examination of the variety of creative arrangements which HMO's have developed with hospitals. (A small number of the largest HMO's own their own hospitals optimizing their control over their delivery system, but most HMO's use the hospitals in their communities.) HMO's can take advantage of the volume of predictable business they can bring to the institution; prompt payment terms; reductions in bad debts resulting from the nature of the coverage (i.e., no payments to collect from the patient) and guarantees of eligibility; and the benefit of progressive HMO efforts to reduce stays and contain costs, such as pre-admission diagnostic testing and early discharge programs.

HMO's (those that do not own their own hospitals) employ various methods to reimburse participating hospitals, depending in part on the above factors. They may pay itemized charges or discounted charges; more typically they pay a more predictble and cost-based all-inclusive per diem rate; some HMO's contract with hospitals to pay for a given number of beds, whether fully utilized or not, providing the institution with guaranteed "occupancy" in consideration for a preferred rate; still other HMO's reimburse hospitals on a capitation basis, providing greater predictability of costs to the HMO and revenues to the hospital.

Regardless of the specific contractual arrangements, HMO's and hospitals cooperate in efforts to share services and optimize the utilization of resources. These can include arrangements to facilitate appropriate treatment of patients who present themselves in emergency rooms; hospitals' agreements to accept the HMO's pre-admission testing, utilization review and early discharge programs; and sharing costly diagnostic and treatment services.

H.R. 3261 exempts hospitals which derive 75 percent or more of the inpatient revenues from HMO's (section 21616(2)(C)), and we support this provision. It recognizes that the use of services in these hospitals is subject to the cost effective practices of the HMO's with which they are associated. The bill also provides that state cost control plans must permit HMO's to negotiate lower rates for inpatient hospital services than those otherwise established. While this provision moves in the right direction, we urge that a more flexible approach be taken. Language consistent with that included in the recent prospective hospital reimbursement program for Medicare (Public Law 98-21) is preferable, since it permits HMO's to negotiate their own rates whether higher or lower than those established under the state system. The overall arrangement negotiated by an HMO with a hospital will contain components which reflect the unique way in which the two HMO controls patient flow and uses services. Maximum flexibility permits creative arrangements beneficial to the HMO, the hospital and the system at large.

Our major difficulty with H.R. 3261 is the provision requiring state cost control plans to require a capitation payment to HMO's not in excess of prevailing rates for comparable services of other providers (section 2142(e)). The term "providers" is not specifically defined in the bill, but the reference to "comparable services of other providers" appears to be all encompassing, including not only inpatient and outpatient physicians' services but also laboratory, X-ray, home health, hospital and other services. There is a fundamental problem in efforts to directly equate the fee-for-service cost of providing services, even when expressed as a capitation payment, with HMO premiums.

HMO's do not maintain records of particular services rendered and the costs associated with them. The principle underlying comprehensive HMO coverages is that, as the HMO act states, for a fixed prepayment care is rendered without regard to the frequency, extent or kind of service actually furnished. By divorcing the payment from the specific services provided, the HMO avoids the fee-for-service incentives to provide more services to generate higher income. A capitation payment that links fee-for-service rates with HMO service delivery is fundamentally at odds with the HMO's operations. It is also extremely difficult to equate fee-for-service rates and HMO premiums in any reasonable accurate way, because cost per service is foreign to the HMO's prospective budgeting process and to the relationships between HMO's and their own medical staffs (and often to relationships between HMO's and the outside providers they use, such as hospitals and specialty physicians).

Further, setting a "capitation payment" to an HMO appears to be an effort to set the HMO's premium. The premium calculation normally includes the HMO's estimate of the total cost for the HMO's membership of providing physicians' services and those of other medical professionals, laboratory and X-ray services, hospital services, administrative services, capital retention for future physical plant expansion and many other elements. The HMO's budget is not simply equivalent to the sum of comparable fee-for-service parts but involves complex estimates of the nature and extent of the services which will be needed by the HMO's projected membership and of the administrative and medical staff and facilities which will be required to provide them. While HMO start-up costs are significant, particularly for a group or staff model HMO, any group or staff model HMO which embarks on the development of a new facility must initially absorb the costs of unused space and personnel while enrolling the membership for which the facility was planned. The HMO must bear this cost while maintaining premium levels competitive with service benefit or indemnity coverages. The notion of a capitation payment to the HMO based upon fee-for-service equivalents fails to recognize the fundamental characteristics of HMO budgeting and operations.

Finally, H.R. 3261 does not attempt to set limits on premiums of the service benefit or indemnity carriers with which HMO's compete directly for enrollment. Presumably, the assumption is that by controlling the cost of the services for which carriers are payors, their premiums will be controlled indirectly. While HMO's are like providers in many respects, they are also like insurers in many respects. The majority of HMO's are payors for hospital services and specialty care, although they may negotiate capitation and other payment arrangements which are reflective of their own cost effective incentives. H.R. 3261 does not seem to take this aspect of HMO operations into consideration.

HMO's have an impressive track record of delivering high quality, efficient comprehensive health care services. If a cost containment provision for HMOs can be crafted which supports the contribution HMO's are already making to controlling escalating costs and which recognizes their structure, relationships to providers and place in the health care marketplace, we would be pleased to see its incorporation into H.R. 3261. We would like to work with the sponsors and the Subcommittee in the development of such a provision as action on H.R. 3261 progresses.

STATEMENT OF JOHN DOYLE ELLIOTT, DIRECTOR, TOWNSEND PLAN NATIONAL LOBBY

Mr. Chairman: The Townsend Plan Movement has consistently endorsed complete national health insurance in the United States ever since adopting that resolution in 1946. Its coverage—as yet incomplete—is a mighty start on the prime road to fullest justice and success in regard to health—life its very self. Medicare is, in fact, national health insurance. It is our unqualified prayer that its full expansion to total coverage of human health insurance be prompt.

Therefore, we hold that H.R. aims most justly at subjecting to honest reason and value delivered the radically climbing cost-inflation of health-care, of LIFE itself.

I most heartily agree that completely competent action through excessive costs, fees beyond reasonable and honest levels deserve prompt and adequate monitoring and control—exactly what H.R. 3261 proposes.

To me, when I witness professional practitioners of health care exploiting through excessive costs, fees and price even more than twice what the great majority of their fellow practitioners require, demand for health care—to me it's thievery based on the most basic thievery, extortion of money in the name of health care, health itself, life itself! To my mind, such charges, extortion of such fees for such services as health care amounts to thievery based on nothing less than utterly excuseless, savage greed.

Medicare is the cornerstone principle of the health industry's most health insuring reality. Medicare's perfection with full coverage for all our people, fully embodies all of the principles to achieve honest competition under the aim and purpose of H.R. 3261—the honest and just employment of all occupations and professions relevant to completed national health—life—insurance.

Up to now, Medicare is the most outstandingly right thing done in the name of Social Security. Medicare does not say to one American that his low record of covered earnings entitles him to only half an appendectomy, for example; while it tells another—however—that his earning record entitles him to a whole appendectomy! But, that is just what social security is still telling people in regard to their bare necessities of life—food, shelter and clothing!

That, despite the reality that we have the problems of social justice because of our misfortuned—not because of the well fortuned.

The time for the lid to go on to that most greedy, excuselessly dishonest savagery and the enactment of law to discern and end it, H.R. 3261; the time for ending that excuseless exploitation of health care, of life itself by people and interests—certainly most aware of what they are doing so savagely—that time is all of the time—and the enactment of H.R. 3261 has long been very overdue.

As our final thought, now, can anything be more in vain than health care for people on living standards which dictate sickness!!!

STATEMENT OF CARROLL ESTES, PH. D., PRESIDENT, AND CHARLENE HARRINGTON, PH. D., CO-CHAIR, PUBLIC POLICY COMMITTEE, THE WESTERN GERONTOLOGICAL SOCIETY

The Western Gerontological Society (WGS) is a national organization of 3,500 members who work with elders or on their behalf. During the past three years, the WGS Board of Directors has instructed its Public Policy Committee and staff to focus on Medicare and Medicaid as its primary policy concerns. This focus has led to the development of policy position papers, training sessions, community leadership at citizen hearings and the development of statements relevant to federal legislation.

This Statement is written in strong support of the Health Care Cost Containment Act of 1983. We believe that this legislation encompasses the basic principles of health care cost containment that are necessary to effect an actual reduction in costs rather than a mere transfer.

Although recognizing the impact of the medical care cost spiral, WGS has consistently opposed strategies that incorporate increased beneficiary cost sharing. For one, over the past three years, beneficiaries have faced steady increases in co-payments and deductibles. Second, and our primary reason for this opposition, is the devastating effect that increased cost sharing has on those elders with low incomes. The Medicare use of flat fee schedules, rather than a sliding fee schedule, places the greatest burden on those least able to afford them. It is unlikely that these elders will have any form of Medigap insurance. Seventy-three percent of those with Medicare only coverage have incomes under $6,000.

These elders are also facing simultaneous cuts in a number of other areas and would consequently be forced into the untenable position of choosing between health care and some other essential need. If these elders confront greater cost sharing requirements for both hospital and physicians, they may delay obtaining needed care. This delay may, in the long run, actually increase costs to government.

Without reviewing in detail other cost containment proposals such as Medicare vouchers, we would like to address the reasons for our support of the Health Care Cost Containment Act of 1983 (H.R. 3261). This legislation covers all sectors that influence costs: hospitals, physicians, health maintenance organizations, ancillary services, and, if possible, skilled nursing facilities. This multi-sector approach is an important avenue to cost-cutting, not cost-shifting.

It also addresses both public and private payors, another essential strategy to avoid cost shifting. It would give states, within federal guidelines, considerable responsibility in the control of health care costs. And the two-year full phase-in period gives to states a needed opportunity to plan for and develop their continuing cost containment mechanisms.

H.R. 3261 is a pragmatic and important step in federal efforts to limit the health care cost spiral. It will do so in a way that will bring the least harm to elderly beneficiaries and will confront the problem at its multiple sources.

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